		,	For State Registrar	State of M		d / Depa		lealth and	d Mental Hy		0 0 5	45	01
	Physici	an.	1. Decedent's Name (First, Middle,						2. Date of De	ath Day	Year	3. Time of D	Death
	/Medic			Arvella	Lill	er			APRIL	20	2005	0910	М
K.	Examin	er .	4a. Facility Name (If not institution, MEMORIAL HOSE		")		4b. City, Town, o		eath		ity of Death		
	Funeral			. Sex 7. A	ge (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 H	Hrs. 8. Date of Bir			lace (State or	Foreign
	Director		220-52-9987 Usual Residence of Decedent	1□M 2√F	55	Yrs.	Months Days	Hours N	Hrs. 8. Date of Bir fin. (Month, Da Aug 17	1949	Couin	lace (State or	
	Marylar a-f show	ctor	WV 10a. State 10b. County Miner	al	10c. City	Wiley					1	0d. Inside City 1 ☐ Yes	
	h with the	Funeral Director	10e. Street and Number P.O. Box 146				10f. Zip Code	26767		10g. Citizen o	f What Cour	itry?	
980	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	þ	11. Marital Status  1 ☐ Never Married     ∑☐ Marrie  3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1	? ] No	- 1	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No Jerto Rican, etc.)	1	ace - Americ lack, White, cify: white	etc.	
Maryland 21215-0036	ithin 72 ho ie. ien "natur Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-40)		(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of	-	16b. Kind of			
121	Hygier Hygier Ither th		12 17. Father's Name (First, Middle, La	ant)		n/a		10 14-11-1-1		n/a			
ylanc	should be fi ind Mental H is marked of umatic ever	To Be	Henry James					Freda	Name (First, Middle Eshbaug	h			
	1 and 2 sho Health and em 27 is m		19a. Informant's Name/Relationship Elnora Penningto			1461	1 McMulle	en Hwy.		ptown	MD	21502	-
Baltimore,	Pages 1 ment of H ent: If ite ury or otl		20a. Method of Disposition  1 ☐ Burial 2 🖫 Cremation 3  1 ☐ Donation 5 ☐ Other (Spe		Scar	pelli Fur	sition (Name of matory or other place neral Home,	<sup>сө)</sup> , РА	Date 4/22/2005	20c. Location		wn, State <b>M</b> E	)
Balt	permit. Page Depurtment Importent: It any injury o		21. Sign, ture of Funeral Service Li	epsee A	M	22	Name and Addre Scarpelli 108 Vira		Home, PA ue: Cumber	land MD	21502		
	Physician Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List or immediate Cause (Final disease or condition resulting in death)	~	diac	Jence of):	er the mode of dyin	ng, such as card	diac or respiratory a	rrest.	2.1302	Approximate Interval Betwo	eath
3760, <	ate be executed hysician and he burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a		ence of):	tery D	risea	se			3 400	
.O. Box 68	es that the death certificate be execuled igned by the attending physician and be detached for use as the buriat-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	1			Date of delive		ear .
s, P	w requires that been signed b should be deta	ed by Pi	Part II. Other significant condition	besity	but not resu	ılting in the u	nderlying cause giv	en in Part I.		obacco use co Yes 2 No	-	e cause of dea	
i Record	The law requires that the ate has been signed by the page 2 should be detache	Completed									. Were autor prior to condeath?	osy findings av	/ailable use of
Vital	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Unanital					Death (Check only o	nne)			
o	Physic this crai dir	<u>۲</u>	1 ☐ Yes 2 Ø No  27. Manner of Death	Hospital: 1 Inpat		ER/Outpatien		4 🔲 (40(5)))	g Home 5 Resi			)	
ou	Attending or death. ector: After by the fune	tion	1 Natural 5 Pending 2 Accident investiga	28a. Date of In (Month, D	ay Year)	Injury	Wor	yat k? Yes 2 □ No	200. Describe	iow injury occi	niied		
Division	of or Attendi efter death. Director: A d in by the fu	Certification;	3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of Ir	njury - At hor atc. (Specify	me, farm, str	eet, factory, office		28f. Location ( City or To	Street and Num wn, State)	nber or Rura	Route Numbe	er,
	To the Hospitel or Attending Physician: The iaw within 24 hours efter death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis and manner s	of examinati	wledge, death ion and/or inv	occurred at the tin vestigation, in my o	ne, date and pla pinion, death or	ace, and due to the ccurred at the time,	cause(s) and r date and place	manner as sta a, and due to	ated. the cause(s)	
	To th withir To th comp	Ž	29b. Signature and title of certifier	1		1	29c. License	e number		29d. Date sigr	ned (Month, I	Day, Year)	
)			Mobustin	w Same	4.	h	D1486	65		ARRI	L 2	3PD 2	005
	10		30. Name and address of person when						AND 350 05	F.0.0			
	Sta	te.	ROBUSTIANO BARRE		OOMEMO		AVENUE (	CUMBERL	AND, MD 21	502			
	Registr		APR 28		100 d	4	المان						<del></del>

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ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland		rtment of H		, ,	iene g. No. 2 N N	5 H.FOO
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Josephine Lillian	Meyer				2. Date of Death	Day 2005	ar 1756 M
<u>}</u>	Examin	er	4a. Facility Name (If not institution, give st Washington County	Hospital		Hagerst			4c. County of D Washin	gton
	Funeral Director		5. Social Security Number  213-82-2806  Usual Residence of Decedent	7. Age (In yrs. las	Yrs.	Months Days	If Under 24 Hrs Hours Min.		941 9.1	Birthplace (State or Foreign Country)  MD
	Maryland	tor	10a. State 10b. County MD Washingto		Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23e or 28	al Director	10e. Street and Number 21730 Ringgold Pi	ke		10f. Zip Code 21742		10	ng. Citizen of What US	Country?
336	urs after dea el', or Items	by Funeral	11. Marital Status 1  1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates:	lf	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, Ihite, etc. White
Maryland 21215-0036	within 72 hou ene. then "neture the wealcal E	Completed	15. Decedent's Educ (Specify only highest grade		(Give I life. D	ent's Usual Occup kind of work done OO NOT use retired aborer	during most of wo	rking	Social S	
land 2	lid be filed lental Hygi ked other ic event, l	To Be Co	17. Father's Name (First, Middle, Last)  Joseph (unk) Meye	r				me (First, Middle, M a (unk) S		
Mary	and 2 shou alth and N 27 Is mar ar treumed		19a. Informant's Name/Relationship (Type Sandra Weaver / C	-		-		ural Route Number, [agerstown		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If time 27 Is marked other then "neturel", or items 23e or 28e-f show any injury or other treumetic event, 112 Medical Examination in the modified at ODGe.		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Lice 158	amoval from State	hsbur	Name and Addre	or. 04/1	8/2005 8	Minnich	g, MD Funeral Home
	Medical Examiner	Examiner	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one limited in the complex shock, or heart failure. List only one limited in the complex shock, or heart failure. List only one limited in the complex shock, and shock in the complex	Due to (or as a consequer	Do not ente	or the mode of dying	ng, such as cardia			Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dlcal	that initiated events resulting in death) Last	Due to (or a conseque	nce of):		dation			
.O. Box 6	that the death certificed by the attending properties as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea: 9 □ Unknown	eath 3	Ectopic pregnancy Other (specify)	1		23d. Date of Month	delivery Day Year
٥	es ign be	by	Part II. Other significant conditions con	tributing to death but not resulti	ing in the un	derlying cause giv	en in Part I.			e to the cause of death?  Probably 4_Unknown
	10 -	Completed						24a. Was ar autopsy perform 1 Yes 2	y prior neg2 death	autopsy findings available to completion of cause of 1? 'es 2 \( \) No
ion of Vita	Attending Physicien: Th r death. ector: After this certificate by the funeral director, pag	To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		R/Outpatient 8b. Time of Injury	28c. Injur Wor	er: 4 Nursing I	ath (Check only one Home 5 Reside 28d. Describe ho	nce 6 Other (S	(pecify)
	or afte Dir	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)				City or Town	, State)	Rural Route Number,
	To the Hospitel within 24 hours a To the Funerel completely filled	Medical	29a. Certifier (Check only one)  2 Medical Examin  29b. Signature and title of certifier	ician: To the best of my knowler: On the basis of examinatio and manner stated.	edge, death n and/or inv	occurred at the tir restigation, in my o	pinion, death occ	urred at the time, da	tuse(s) and manner ate and place, and of the date signed (Mice)	due to the cause(s)
)	Mil Tool	_	> Fain w	when		000	60396	S	04/17/	o S
5	H-2 Sta	te	30. Name and address of person who con FARID MUM  31. Date filed (Month, Par Year) 20	SHED		Print) 112	Hagers	nvot	MD	21740
	Regist		AFK 10 20	32. Registrar's Signatur	· Gi	exted				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2005 **Physician** April 16, Charles Eldridge McGOWAN 0500 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 1103 Pope Avenue Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. July 1, 1 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months West Virginia 1⊠M 2□F 88 1916 212-12-7880 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or items 23a or 28a-f show other treumetic event, the Modical Examination and be notified at 1 X Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1103 Pope Avenue 21740 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married XYes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 T No Specify: white Specify: Completed by 3 - Widowed 4 - Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) s 1 and 2 should be filed within Health and Mental Hygiene. tem 27 is marked other then Elementary/Secondary (0-12) 0-5 College (1-4or 5+) refrigeration manufacturer laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Nelson McGowan Ida Virginia Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arbanna S. McGowan - wife 1103 Pope Avenue, Hagerstown, Maryland 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Cedar Lawn Memorial Park ō <u>=</u> 1 Burial 2 □ Cremation 3 □ Removal from State ō April 20, 2005 Hagerstown, Maryland Department of Importent: If any injury or \* 4 ☐ Donation 5 ☐ Other (Specify) Minnich Funeral Home 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** arteriosclerotic cardiovascular disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown ģ been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, severe osteoporosis 1 X Yes 2 No 3 Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed certificate 1 Yes 2X No 1 Yes 2 □ No Physicien: director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) Certification: To 1 XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident nin 24 hours after deat the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, Jarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide Hospitel or filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. So stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical pletely (Check only onel within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2 70-1062 2005 DIH IIN N Cur Wi de 30. Home and address of person who completed cause of death (Item 23a) (Type, Print) Edward W. Ditto, III, M.D., 19011 Orchard Terrace Rd., Hagerstown, Md. 21742

Registrar

State

31. Date filed (Month Par Year)

32. Registrar's Signature

			For State Registrar	State	of Marylar		artment					iene	05	14504
	Physici	an	1. Decedent's Name (First, Middle Edith Pearl Me			·					2. Date of Dea	th Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution		ım ber)		4b. City,	Town, or	Location of	of Death	Hpril	-	y of Death	1
1	LXanını		Washington Cou	inty Hosp	ital		1		rstow					ngton
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.		If Under		If Under Hours		8. Date of Birth (Month, Day) June 22	Year)		place (State or Foreign ntry)
	Director		215-14-1425 Usual Residence of Decedent		86	Yrs.					June 22	,1918	Tenn	essee
	yland now		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				-			10d. Inside City Limits
	e Mar	ctor	Maryland Was	hington		Hage	rstow	n						1 X Yes 2 □ No
	or 28	Directo	10e. Street and Number				10f. Zip				1	0g. Citizen of		ntry?
	eath v	eral	240 S. Potomac		cedent Ever in U	C 123	Man Doord	217		ning (Co	aif. Var. as Na	US		can Indian,
(0	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Modical Examitrations to modified at	Funeral	1 Never Married 2 Marri	ied Armed F	orces? 2 🔯 No						ecify Yes or No- Rican, etc.)		ick, White,	
ğ	ours a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	ive Dates:		1☐Yes 2	No No	Specity:			Specia	√y: wh:	ite
2	"natu	lete	15. Deceden (Specify only highe	t's Education st grade completed	)	16a. Dece (Give	dent's Usual kind of wor DO NOT us	Occupa k done d	ation during mos	t of worki	ng	16b. Kind of E	Business/In	dustry
2	withir lene. than	Completed	Elementary/Secondary (0-12)	College 0	(1-4or 5+)		al bo					airc	raft	mfg.
<u>5</u>	e filled Il Hygi other	Be C	17. Father's Name (First, Middle,	Last)						er's Name	(First, Middle, I			
<u> a</u>	wuld be Menta Arked	To B	Joe McNabb						Lauı	ra Bl	Levins			
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, Ite Modical Estimation institutional to rediffer all		19a. Informant's Name/Relations								l Route Number			
	1 and Health 6m 27 ther t		Anne Cox - P.  20a. Method of Disposition	R.	20h F	64 Place of Dispo			nal I		Hagers	town, 20c. Location		
ğ	Pages nent of I ant: If its ary or o		1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S		State	eenlaw	natory or ot	her place	1					t, Maryland
altimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service		GI						ICH FUN			t, Maryiano
ä	Per Imp		DOPEN	MA	Juna						Hagers			1740
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat each line.	h. Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition	Q	inal	Fai	INAS							Onset and Death
Ŀ	/Medical Examiner		resulting in death)	Due to	(or as a conseq		0							
		e	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury	b. — Due to	Or as a donsey	uence of):		100					-	
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	S (	Longe	stive	H	e at	4	Fail	1 W ~ ~			
Ö,	be executed sician and burial-transit	EX	resulting in death) Last	Due to	(or as a seq	uence of):								
8760	cate b physic the bi	dlcal		d						-				
9 xo	death certificate be executed e attending physician and od for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	itcome of pregna	ancy						334 Da	ate of delive	200
m	death e atter	Iclai	in the past 12 months?	4□Preg	birth 2□Feta nant at time of d		]Ectopic pre ] Other ( <i>spe</i>					1	onth	Day Year
o.	at the by th	hys	9 🗆 Unknown	9□ Unkr										
	The law requires that the de the has been signed by the a page 2 should be detached	by	Part II. Other significant condition	ons contributing to o	leath but not res	ulting in the ur	nderlying ca	use give	n in Part I.			_		ne cause of death?
Š	requi	eted									-	s 2□No		
Records,	e lav has ge 2	Completed									24a. Was ar autops perforn	/	Were auto prior to coo death?	psy findings available mpletion of cause of
Viital	10 -	e Co	25. Was case referred to medical					<del>.</del>	OC Disease	of Dooth		₩6		2 No
	ysicis is cert direct	27. Manner of Death 1											ner (Specifi	v)
0	ng Ph										8d. Describe ho			,,
<u> </u>	tendi Jeath. for: A the fu													
Division of	l or At after o Direct	ertif	4 Homicide determ	ined 28e. Place build	e of Injury - At ho ling, etc. (Specif	ome, farm, stre y)	et, factory,	office		2	Bt. Location (Str City or Town	reet and Numb , State)	oer or Rura	il Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 ☐ Certifyin	g Physician: To th	e best of my kno	wledge, death	occurred a	t the time	e, date and	d place, a	nd due to the ca	use(s) and ma	anner as st	tated.
	vithin 24 Vithin 24 To the Fu	Medical	one,		ner stated.	tion and/or inv				th occurre	d at the time, da	ite and place,	and due to	the cause(s)
	To To	2	29b. Signature and title of certifier	hered					number 603	96	29	d. Date signe	d (Month,	Day, Year)
			30. Name and address of person	who completed	en of death /h	1000) /T 1		126		ral		711	0 (0)	
3F	1-3		FARID MU	RSHED	se or death (Item		ran) (	120			town	mn	217	40
	Sta		31. Date filed (Month) Par Year)	9 2005 32.5	Registrar's Signa	ture	/		NA	*)~``	,	1	- 1	1
	Registr	ar		-000	Billion ,	19. 3	ander							

			1 - State Registrar	State of Maryland /	•	tment of Hericate of L		,	giene Reg. No. a	Star Star was	
I	Physici		1. Decedent's Name (First, Middle, Last) Francis Eugene	Markle				2. Date of De	ath Land	Year 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	4	lb. City, Town, or Haq	Location of Dea		4c. Coun	ity of Death	n County
	Funeral Director		5. Social Security Number 6. Sex 183–16–5267		, A	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	th	9. Birth	place (State or Foreign ntry) sylvania
	Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Washing	ton Hac	or Local						1 ☐ Yes 2X No
	ath with the	rai Directo	10e. Street and Number  19512 Longmeadow	Road		10f. Zip Code 217			10g. Citizen o Unite	d Sta	tes
036	urs after de ei', or items Exandrech	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	<ul> <li>12. Was Decedent Ever in U.S. Armed Forces?</li> <li>1 Xyes 2 □ No If Yes, Give Year or Dates:</li> </ul>		s Decedent of Hises, specify Cubar	spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	BI	ace - Americ lack, White, cify: Wh:	etc.
21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "neture"; or items 23a or 28a-f show matic event, the MacLeal Examinational Demotified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		a. Deceder (Give kir. life. DO	nt's Usual Occupa nd of work done d NOT use retired)	tion uring most of wo	orking	16b. Kind of	Business/In	dustry
73	e d a b	To Be Co	12 17. Father's Name (First, Middle, Last) Edward Robbins	Markle		Machinia	18. Mother's Na	ıme <i>(First, Middl</i> e Sweitzer			J•
	s 1 and 2 should if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty,	(wife)	195	12 Longii	nd Number or F	Rural Route Numb	er, City or Tow stown	n, State, Zip Marvl	and 21742
altımore,	Page nent o ant: if ury or		20a. Method of Disposition  1  Burial 2	emoval from State Cedar	ery, cremai Lawn	ion (Name of tory or other place Mem. Pa	rk Apr	. 18 05	20c. Location Hage1		Maryland
Ba	permit. Departinoporta importa any inji		23a. Part 1. Enter the disease, or compli	cations that caused the death. Do			D	ouglas A N. Hage	. Fiery	y Fune Maryl	eral Home and 21742
	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence							Interval Between Onset and Death & Mon A
	Examiner	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence							
8760,	icate be executed physician and sthe buriai-transit	dical Examine	that initiated events resulting in death) Last	Due to (or as a consequence	of):						
. Box 6	death certifi e attending ed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown		ctopic pregnancy other (specify)				Date of deliver	ery Day Year
rds, P.O	The law requires that the tee has been signed by the bage 2 should be detache	by	Part II. Other significant conditions cor	tributing to death but not resulting	in the unde	erlying cause give	n in Part I.		_		ne cause of death?
Il Records,	The law re cate has bee page 2 sho	Completed						24a. Was auto perfo 1 \( \text{Yes}	rmed?	D. Were auto prior to co death? 1 \( \subseteq Yes	psy findings available mpletion of cause of 2 No
VIE	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		20 DOA Othe	P7	eath (Check only o			
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	I   Inpatient 2   EH/C	Time of Injury	28c. Injury Work	4   Nursing	Home 5 Aesi 28d. Describe			y)
Divis	ital or Atter rs after dea al Director ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street	t, factory, office		28f. Location ( City or To		nber or Rura	il Route Number,
	the Hosp nin 24 hou the Funer npletely fill	Medical	one)	sician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death o nd/or inves	stigation, in my op	inion, death occ	e, and due to the curred at the time,	date and place	e, and due to	the cause(s)
ı	or with	~	29b. Signature and title of certifier	milaune	120	29c. License	1166 "	ח	29d. Date sign	ned (Month,	
61	4-7+1										
	∜ Sta Registr		31. Date filed (Month Day Year) 9 2	mpleted cause of death (Item 23a)  10 Cormacia  32. Registrar's Signature	1111	estes	Ulcel	cay v	3 1/2	1000	100 1NO

			1 - For State Registrar	State of Ma	aryland / Depa Ce	artment of H			ene 0 (	)5	145	106
			Decedent's Name (First, Middle, Last)					2. Date of Death			3. Time of D	Death
П	Physici /Medio		Melda Kay McMillar	1				April		Year	020	PM
}	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of De	ath	4c. County o	f Death		
		٠	Washington County			Hagerst			Washi			
	Funeral Director		212-24-0901	7. Ag	e (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		<sup>(ear)</sup> 927	9. Birthplace Country) Mary I	}	Foreign
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d.	Inside City	y Limits
	Manyl f sho	ō	Maryland Washingt	on	Williamsp	ort					1 XYes	2 🗌 No
	1 the	Director	10e. Street and Number	011	WITTIGHTSP	10f. Zip Code		100	. Citizen of Wh	nat Country?	?	
	h with	ai D	113 East Sunset Av	e.		21795			USA			
	ems sem	ner	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of H	ispanic Origin?	(Specify Yes or No-		- American I White, etc.		
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23s or 28e-f show or other traumatic event, the Mactical Examinat must be notified at	by Funerai	1 Never Married 2 Married	1 Tes 2 X	No	1 ☐ Yes 2 ☑ No	Specify:	310 1 1001	Specify:			
Ö	hours tural'	a pa	3 Widowed 4 Divorced	Year or Dates:		dent's Usual Occup	ation	14		White		
T. Sy	in 72 n "na	Completed	(Specify only highest grad	e completed)	(Give	kind of work done of DO NOT use retired	during most of w	vorking	b. Kind of Bus	mess/maust	,ry	
212	d with giene. rr thai	E	Elementary/Secondary (0-12)	College (1-4or 5		ing Hoste	SS		/ending	Mach i	ines	
힏	e filed al Hygi I other vsnt, I	BeC	17. Father's Name (First, Middle, Last)					lame (First, Middle, Ma		)		
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Jar	2 shot and ls m		19a. Informant's Name/Relationship (Ty	•		-		Rural Route Number, (	•			
e,	s 1 and 2. of Health ar litem 27 is		Teresa A. Stottlem 20a. Method of Disposition	yer-Daugh	20b. Place of Dispo		alley Dr	ive Hager	STOWN, M c. Location - C			
פֿר	Pages nent of th int: if Ite		1 XBurial 2 ☐ Cremation 3 ☐ P	emoval from State	cemetery, crea	matory or other place		1				al
Baltimore, Maryland 21215-0036	artmer artmer ortant injury		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signatur	AA	Cedar Law		1		agersto		•	a
Ba	permit. Pages 1 and Department of Healt Important: if Item 2 any Injury or other QDCS.		>//log~////	Xl-				sborne Fune ue St. Wi				95
			23a. Part1. Enter the disease, or compl shock or heart failure. List only or	cations that caused ne cause on each li	I the death. Do not en	er the mode of dyin	g, such as card	iac or respiratory arres	t,	Inte	proximate terval Betwe nset and De	reen
	Priysician		Immediate Cause (Final disease or condition resulting in death)	Hypo	xemice					011		Dati 1
	/Medical Examiner		Todalling in doubly	Due to or as	a consequence of):	6500	SMA	ll cell l	1105 0	0.00	ø	
		e l	Secuentially list conditions, if any, leading to immediate	Due to (or as	a consequence of):	OSIEICC	3144	[[ ((() (	CVIJ C	CEMEN		
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	·	. ,							
വ്	exection and and rial-tra	Exa	resulting in death) Last	Due to (or as	a consequence of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		I								
9	artifica ing ph e as th	(a) t	IF FEMALE:									
Вох	eath certifi attending     for use as	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy	,		23d. Date Mont	,	v Ye	ear
P.O.	that the death certificated by the attending posterior of detached for use as	Completed by Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	time of death 5L	Other (specify)				=,		
م:	that the od by detact	-P	Part II. Other significant conditions con	tributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contrib	oute to the ca	ause of de	ath?
Vital Records,	w requires t been signe should be	d b	precionic, (	R) (au	er lobe			1 🗆 Yes	2 No 3	☐ Probably	/ 4 □Un	nknown
S	w req	lete						24a. Was an	24b. We	ere autopsy	findings av	vailable
Be	The lav te has age 2:	mo du						autopsy	d?/ pri	or to comple ath?	etion of cau	use of
<u>ta</u>	ician: Th certificate rector, pag	a)	25. Was case referred to dical		/		26. Place of D	eath (Check only one)	ano IL	Yes 2	INO	
	Physici this cer al direc	To B	examiner? 1 ☐ Yes 2 ☑ No	lospital:	ent 2 ER/Outpatier	nt 3 DOA Oth	00	Home 5 ☐ Residen	e 6 □Other	(Specify)		
Division of	Attending Physician: or death. ector: After this certification by the funeral director,	Certification; T	27. Manner of Death  1	28a. Date of Inju (Month, Da	ry y Year) 28b. Time o Injury	Worl	y at k? Yes 2 □ No	28d. Describe how	injury occurred	i		
/ISI	Attendir death.	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inj	ury - At home, farm, st			28f. Location (Stre		or Rural Ro	oute Numbi	er,
ă	s after s after s Dire	Cert	4 Homicide	building, et	c. (Specify)			City or Town,	State)			
	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best ner: On the basis of and manner sta	of my knowledge, deat f examination and/or in ated.	h occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the cau curred at the time, date	se(s) and mann a and place, an	ner as stated d due to the	d. cause(s)	
	To th within To th	Me	29b. Signature and title of certifier	0		29c. License	e number	290	. Date signed (	Month, Day,	Year)	
)			Frum @ X	Deese LO	> Hespita	HO	0611	7 A	pril 1	7 2	005	_
			30. Name and address of person who co			Print)	0 ~			1		^
5	4-4		HRONCISCO A	Deniel	1	251 E.	AUTIE	Iam SI	Mage	15704	MM	$\mathcal{U}_{\perp}$
	Sta Registr		31. Date filed (Month, Pay, Year)	32. Registr	ar's Signature	A CHEST		ŕ			217	40

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** CATHARINE ROMAINE MORRIS 22 2005 April 3:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford 620 Sadler Street Aberdeen If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 ☐ M 2 ☐ XF 220-22-0168 Yrs 90 2/6/1915 Director Pennsylvania Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itams 23a or 28a-f show injury or other traumatic event, the Mudical Examinary ust be notified at 1 ☐ Yes 2 No Director MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 620 Sadler Street 21001 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ Specify: White 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other trainmetin. Elementary/Secondary (0-12) College (1-4or 5+) Civil Service 12 Administrative Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Abel Morris Eliza Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy I. Morris/Niece 3521 Delta Road, Airville, PA 17302 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Bryansville Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 4/26/2005 Delta, PA 21. Signature of Funeral Service License 22. Name and Address of Facility Harkins Funeral Home, Inc., 600 Main St., Delta, PA 17314 23a. Part1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STA /Medical **Examiner** Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown á signed b d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 10 1 ☐ Yes 20 No 1 Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) After this c funeral dire 1 🗌 Yes 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Natural 5 Pendina death. 1 ☐ Yes 2 ☐ No investigation in by the 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 \( \text{Homicide} \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eath (Item 23a) (Type, Print) 13 Registrar's Signature State Registrar

		,	1 - For State Registrar	State of Maryland	Department of F		ental Hygie	6000	14508
İ	Physici /Medio		Decedent's Name (First, Middle, Last)     CHRYSOULA	MATHAS			2. Date of Death	Day Year	3. Time of Death 9 • 56 pm
	Examir		4a. Facility Name (If not institution, give s.  MILSON HEAL  5. Social Security Number 6. Sex	TH CARE CEN	TER GAITHE	RSBURC ;	m. 30877	4c. County of Death	MERT
	Funeral Director		395-20-2486 Usual Residence of Decedent	M 21x 77	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye May 8, 19		nplace (State or Foreign Intry)
	the Marytan 28e-f show	rector	10a. State 10b. County  Maryland Montgomer  10e. Street and Number		ersburg		10a.	Citizen of What Co	10d. Inside City Limits 1 XYes 2 No
036	72 hours after death with the Maryland neturel', or Hems 23a or 28e-f show alsol Examil at must be indiffed at	by Funeral Directo	13 Duvall Lane  11. Marital Status  1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Was Decedent Ever in U.S. Armed Forces?     □ Yes 2 MNo If Yes, Give Year or Dates:	20877  13. Was Decedent of H If Yes, specify Cuba  1□ Yes 2⊠ No	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	Ur	14. Race - Amer Black, White Specify:	Ces ican Indian,
21215-0036	d within 72 ho giene. er then "netur tre Medicul	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation 16 completed) 16 College (1-4or 5+) 5+	6a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired Teacher	durina most of working	Mi	Llwaukee	ndustry
Maryland	d 2 should be filed within 7 h and Mental Hygiene. 7 Is marked other then "r treumatic event, the Mad	To Be (	17. Father's Name (First, Middle, Last)  Thomas Mathas  19a. Informant's Name/Relationship (Type	pe. Print) 1	19b. Mailing Address (Street	18. Mother's Name Panayiota	Christon	oulos	in Code)
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or items 23a or 28e-1 show entigury or other treumatic event. Ite Marking Examinating the indiffed at once.		Katherine Panagos  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Euneral Service License	(Sister)  20b. Place ceme  Gat	13 Duvall Lan of Disposition (Name of etery, crematory or other place e of Heaven C	Cemetery 4	rsburg, M 200 /14/05 S	D 20877  Location - City or 1	own, State
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complicance, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Failure to T	Gaithersbu On not enter the mode of dyin hrive ce of):	irg, MD 208	377		Approximate Interval Between Onset and Death 1 Month
8760,	icate be executed physician and sthe burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	ce of):				
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	ac. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 ☐ Ectopic pregnancy	,		23d. Date of delive Month	very Day Year
	w requires that been signed should be det	by	Part II. Other significant conditions cond Hypertension, Bila					co use contribute to 2 ⊠No 3 ☐ Pro	the cause of death? bably 4 Unknown
Vital Records,	The ate h page	Completed	Carcinoma, Reflux Peripheral Vascula				24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of 2 ☑ No
of	Attending Physicien: The rideath. death. ector: After this certificate had the funeral director, page	ıtlon: To Be	25. Was case referred to medical examiner?  1  Yes 24 No  27. Mann r of Death 1  Natural 5 Pending 2  Accident investigation	ospital: 1   Inpatient 2   ER/ 28a. Date of Injury (Month, Day Year) 28b	b. Time of 128c. Injury Work	4 Nursing Hom		e 6 ⊡Other (Speci njury occurred	(fy)
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, factory, office	28	Bf. Location (Stree City or Town, S	t and Number or Rui tate)	al Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Direction places on the Funerel Direction by	Medical	(Check only 2 Medical Examin	er: On the best of my knowled er: On the basis of examination and manner stated.	and/or investigation, in my o	pinion, death occurred	d at the time, date	and place, and due	to the cause(s)
)	F 6	_	29b. Signature and title of certifier  A La Liza Liza  30. Name and address of person who cor	French Course of death liver co.		D 04115		Date signed (Month)	
	Sta Registr		H. Robert Birschba 31. Date filed (Month, Day, Year)  APR 1 3 200	ch, M.D., 201 I	Russell Avenu	e, Gaither	sburg, M	D 20877	

			1 - For State Registrar	State of Ma	ryland				lealth ai Death	nd Mer		ene g. No.	105	14509
H	Physici	an	1. Decedent's Name (First, Middle, La		77						Date of Death Month	Day 2005	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, given	th Doyle Mcl	kee		4b. City,	Town, or	Location of		ri1 9,		ounty of Death	7:00 p.m. <sup>M</sup>
	LAdmii	CI	Manor Care					Pot				1	Montgo	mery
	Funeral			Sex 7. Age 1 ☐ M 2 Top F	-	st birthday)	If Under Months	1 Year Days	If Under 24 Hours	4 Hrs. 8. Min.	Date of Birth (Month, Day,	Year)	9. Birth Co	hplace (State or Foreign
	Director		Usual Residence of Decedent	-X	78	Yrs.				Ju	11y 30,	1926	6 New	York
	yland how		10a, State 10b, County		10c. City,	Town or Lo	cation	-						10d. Inside City Limits
	Ba-fs	Funeral Director	D.C.		Wash	ningto	n							1 ☐ Yes XXNo
	with th	Dire	10e. Street and Number				10f. Zip				10	_	n of What Co	untry?
	eath v	eral	2737 Devonshire	12. Was Decedent E		13.1		008	ienanie Origi	in? (Specifi	Vas or No		.S.A.	rican Indian
(O	riter d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No						Puerto Ric	y Yes or No- an, etc.)		Black, White	e, etc.
<u> </u>	72 hours after death with the Maryland natural', or itams 23a or 28a-f show dreal Evantine fount be redified at	d by	3  Widowed 4 □ Divorced	If Yes, Give Year or Dates:			I□Yes :	2 <u>K</u> J No	Specify:			Sp	pecify: Wh	ite
5-(	"natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	ient's Usua kind of wor	al Occupa	ation during most o	of working	11	6b. Kind	of Business/I	Industry
12	withir Bne. then	dwo	Elementary/Secondary (0-12)	College (1-4or 5+	-)		rtise		,		1	Ernes	st Joh	nston
פַ	e filed II Hyg other vent,		17. Father's Name (First, Middle, Las	1)					18. Mother's	s Name (F	irst, Middle, M			
ylar	Menta Menta Brked	To Be	Unknov						J	esse	Doyle			
Maryland 21215-0036	d 2 sho in and 7 is m traum		19a. Informant's Name/Relationship Virginia McKee De	(Type, Print) ering/daug	n hter	19b. Mailin	ig Address Mauzv	(Street a	and Number ad Be		oute Number, o			
ē,	Heall Heall Hem 2		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Nan	ne of	1	Date	20	-	tion - City or 1	
<u>ii</u>	Page ment o		1 ☐ Burial 2 【 Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci		Mt.	Comic	rt	шөг рас	4/	13/05	6 A:	lexar	ndria,	VA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury go, either traumatic event, the Medical Exactine count be retified at once.		21. Signature of Funday Service Lice	nsee Son						_	Gawler NW WD0		Sons, 0016	Inc.
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on each line	9.							st,		Approximate Interval Between Onset and Death
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8760,	cate be executed physician and the burial-transit	al Ex	resulting in death) Last	Due to (or as a			ncv							
687	ficate physics the	edica		d										
Вох	death certific e ettending p id for use as i	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			15-4					23d.	l. Date of deliv	very
	0 0 0	Physician/Medical	in the past 12 months?	4☐Pregnant at ti			Ectopic pro Other (sp						Month	Day Year
P.0	hat the		9 ☐ Unknown  Part II. Other significant conditions		t not result	ting in the ur	odorkina o	21160 001	on in Part I		23a Did toba	CCO USA	contribute to	the cause of death?
ds,	requires that the een signed by th hould be detache	d by	3				oonying or	auso give						bably 4 Unknown
CO	aw requir as been si 2 should	olete									24a. Was an	24	4b. Were au	topsy findings available
Vital Record	9 7 9	Completed									autopsy performe	od? ∑ No	prior to codeath?	completion of cause of
/ita	ysicien: Th nis certificate director, pag	Be	25. Was case referred to medical examiner?							of Death (C	heck only one)			
of	Phys this al dir	T.	1 ☐ Yes 2 🛣 No 27. Manner of Death	Hospital: 1 Inpatient					4 (AIVUIS		5 Residen			cify)
on	ding h, After fune	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	M	8c. Injury Work	res 2.∐No		. Describe how	Riquity Oc	curred	
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur	y - At hom	ne, farm, stre	et, factory				Location (Stre	et and No	umber or Rui	ral Route Number,
Ö	Hospital or A 24 hours after Funeral Directely filled in by			building, etc.							City or Town,			
	To the Hospital or within 24 hours afte To the Funeral Dit completely filled in	Medical	29a. Certifier  (Check only one)  (Check only one)	hysician: To the best of miner: On the basis of e	examinatio	ledge, death on and/or inv	occurred a estigation,	at the tim	e, date and pointion, death	place, and occurred a	due to the cau at the time, dat	se(s) and e and pla	d manner as acce, and due	stated. to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of centifier,	and manner state		ra A	290		number				igned (Month	
)	00		> parti	Vow		M, 1	7	D-2	20274		A	pril	11, 2	005
	30		30. Name and address of person who					,	100	0001	,			
			Kirti Vohra, M.D. 31. Date filed (Month, Day, Year)	. 7710 Brad		150		esda	<b>,</b> MD	20817				
	Sta Registr	_	APR 1 3 20		K	Loc	L'							

			1 - For State Registrer	State of M	larylan		artmen rtificat					giene	A	5	11.510
	Physici	an	Decedent's Name (First, Middle, La     Norma Montero	st)							2. Date of Dea Month April 10		Ϋ́5	ear	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give	re street and number	-)		4b. City.	Town, or	Location of				County of I	Death	8:30 A "
	Examir	ier	16303 Spring Wat		<i>'</i>			ockvi		or Dodan					•••
	Funeral	7	5. Social Security Number 6. S	Sex 7. A	ge (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birt (Month, Da	h	Montg 9.		ice (State or Foreign y)
	Director	9	450-65-5136	1□M 21XF	86	Yrs.	Months	Days	Hours	Min.	Sep. $6,1$	y, rear) 918		hile	
	p .		Usual Residence of Decedent  10a. State 10b. County		100 Cib	, Town or Lo								140	4 1
	shov	5	, and the second		Too. Oil									100	d. Inside City Limits 1 ☐ Yes 2 ☑ No
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	ns 23a	era	16303 Spring Wat	12. Was Deceden	t Ever in U.	S. 13.	Was Dece	208 dent of Hi		igin? (Spe	city Yes or No		Chil		n Indian.
(0	riter dea	표	1 Never Married 2 Married	Armed Forces	?						cify Yes or No- Rican, etc.)	1	Black, \	White, et	ic.
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and	be fi	Be	17. Father's Name (First, Middle, Last	,					18. Mothe	ers Name	(First, Middle,	маюеп	Sumame)		
Ž	d Mer nark	2	Jorge Montero  19a. Informant's Name/Relationship	Tuna Briati		10b Maili	n - Address	(Ctro at a	Luc		Zamor		Taura Ota	4= 7i= 6	>
Maryland	d 2 sho th and 7 is mu treum										l Route Numbe				
	1 and Health em 27		Norma X. Lucas  20a. Method of Disposition	Daughte	20b. P	1614	osition (Na	me of			ston-S		NC ocation - Cit		
JOL	Pages nert of nrt: # Its		1 ☐ Burial 2 🖸 Cremation 3 [		Meti	<sub>emetery, cre</sub> copoli	matory or o	other place							
Baltimore,			<ul> <li>4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice</li> </ul>				Crema 2. Name ar		s of Facilit	Apr.1	3,2005	Ale	xandri	ia,V	irginia
Ba	permit. Departr Importe any Inju		٨ د ٨	5-0		Fr	ancis	s J.	Co11:	ins E	Tuneral				
			23a. Part 1. Exter the disease, or com	plications that cluse	ed the deat!								Spri	1	m 20901 Approximate
	Dhuninian		shock, or heart failure. List only Immediate Cause (Final												nterval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. <u>Athero</u> Due to (or a							<u> </u>			1	0+ yrs.
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	The law requires that the death certificate be executed the saben signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	that initiated events	С.											
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9	death certifica attending ph afor use as the	Mec	IF FEMALE:			<u>.</u> .								- 4	
Вох	ath catternation or us	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 Feta	Ideath 3[	Ectopic p						23d. Date of Month		/ Day Year
	the a	sic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of d	eath 5L	Other (s	oecify)						_	,
P.O.	s that the death		Part II. Other significant conditions	contributing to death	but not res	ulting in the I	ınderlyina (	ause dive	en in Part I		23e. Did to	obacco i	use contribu	te to the	cause of death?
Records,	uires thai signed t d be det	d by	Alzheimer's Di					-			_	es 2	_		bly 4 ∐Unknown
Ö	w requir been si should I	Completed									24a. Was		1		nu findings qualishts
Re	ne fav has ge 2	d E									autop		prio	r to com; th?	sy findings available pletion of cause of
a	ilcien: The fav certificate has rector, page 2		25. Was case referred to medical	1					00.51	- 15 "		200 No	1 🗆	Yes 2	!□ No
of Vital	Physicien: The tithis certificate har all director, page	o Be	examiner?	Hospital: 1 ☐ Inpa	tiont 2	ER/Outpatie	nt 3□ D0	Othe			(Check only one 51€ Resident		e Clother (	(Cons. 6.)	
of	a Phy ar this aral d	n: To	27. Manner of Death	28a. Date of In	jury	28b. Time o	_	28c. Injury Work			28d. Describe			<i>Specify)</i>	
ion	Attending F r death. sctor: After by the funer	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, E	ay rear)	Injury	М		<br Yes 2 ☐	No					
Division	Attendi	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	289. Place of I	njury - At ho	ome, farm, st	reet, factor	y, office		2	28f. Location (S City or Tox			or Rural i	Route Number,
Ö	s effe el Dir	Cert	4 Difficial	building,	экс. (Зрасп	γ)				- 6	City of You	m, Siate	*/		
	To the Hospitel or Attent within 24 hours effer deatl To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exe	hysician: To the bes miner: On the basis and manner:	of examina	wledge, deat tion and/or ir	th occurred nvestigation	at the tim	e, date an pinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s date and	) and manne d place, and	er as star	ted. he cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	-1-	446		29	c. License	number			29d. Da	te signed (A	Month, D	ay, Year)
	. 1		I puls Pla	udo2	MD				5152			۸	41 10	20	105
	4	1 3	30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type	Print)		1112			Apr	il 12	<b>,</b> 20	
175			Gino Mendoza, N	.D. 47	01 Ra	ndoInh	Road	#10	1 R	ockví	11e. M	arv1	and	2085	2
	Sta Regist		31. Date filed (Month, Day, Year)	A. Regis	trar's Signa	ture	180					,			

Funer Direct

Division of Vital Records, P.O. Box 68760,	el or Attending Physician: The law requires that the death certificate be executed safer death	al Director: After this certificate has been signed by the attending physician and had in by the funeral director, page 2 should be detached for use as the burial-transit
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	1 - State Registrar Amend 1. Decedent's Name (First,			FH; FCH			e of D	Outing	-11104/	2. Date of De		0,2	44	3. Time of	Dea
n	JOAN	modic, Edo	В	M	ILLER					Month APRIL	Da	ay 2005	Year	8:58A	
al	4a. Fecility Name (If not ins	titution, give			TUUER	4b. City.	Town, or L	ocation o		AFKIL			of Death		_
er	Frederick	_			a l		deri						deri		
	5. Social Security Number	6. Se	ex	7. Age (In yrs.		If Under	1 Year	If Under 2		8. Date of Bi (Month, D	irth	.,	9. Birth	place (State or	For
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	Usuel Residence of Deceder			10c Cit	ty, Town or L	ocation								10d. Inside Cit	v Liv
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Director	Maryland  10e. Street and Number 7	Frede	rick		Frede	rick 10f. Zip	Codo				10a C	itizon of l	What Cou		
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þ	3 ☑ Widowed 4 □ Div		If Yes, G Year or I	ive		1 🗆 Yes	2 No	Specify:				Specif	v: Wł	nite	
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Be	17. Father's Name (First, M	fiddle, Last)					1	_		(First, Middle	e, Maide				
2	Luther			tzer					chel				ggle		
ā	19a. Informant's Name/Re			1.			•			I Route Numb				p Code)	
	Peggy Jo Kor		WSK1/da		6UZ			Ave.,		w Marke				Chata	
	20a. Method of Disposition 1 🗆 Burial 2 📆 Crem		Removal from	State	cemetery, cre	matory or c	other place)							own, State	
	`4 □Donation 5 □Ot			Fr				- 1		/2005				aryland	
	21. Signature of Funeral S	ervice Licer	See		/									es, P.A	. •
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	23a. Part1. Enter the disease shock or heart failure	ase, or com	Diications mat		th Donot or								, , ,	Approvimate	_
	Language Course (Circle	e. List only	one cause on	each line.	th. Do not er									Approximate Interval Betwood Onset and D	veer
	Immediate Cause (Final disease or condition resulting in death)	e. List only	one cause on	each line.	tage	ler the mod	de of dying,	such as	cardiac c					Interval Bety	veer
		e. List only	one cause on	caused the deal each line.	tage	ler the mod	de of dying,	such as	cardiac c					Interval Bety	veer
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month James G. McFall PRI 2005 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury renin sula Vicom ico Kegional 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last blithday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1∭M 2□F Yrs. 1939 New Jersey **Director** 149-28-0375 66 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 17 is marked other than "naturel", or items 23a or 28a-f shor traumatic event, the M. dical Examiner must be notified at 1 X Yes 2 □ No Completed by Funeral Director Sussex Lewes Delaware 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19958 USA 3 Aspenwood Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 0 5 0 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No 1958− If Yes, Give Year or Dates: 1964 filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Heelth and Mental Elsie Ludmann John McFall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heelth item 27 i othar tra 3 Aspenwood Drive, Lewes, DE 19958 Alice A. McFall/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: if it any injury or o 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) cemetery, crematory or other place) Department Hollywood Mem. Park 4/21/2005 Union, New Jersey 21. Sign vuie of Fur eral Service Vic in see Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, MD21802 Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Valvo disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a consequence of): Examine physicien and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2**X** No or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No i Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D62107

State Registrar

0375

560

Rius de Drive Solisbu

wo

MI

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

31. Date filed (Month, Day, Year)

APR 18

		-	1 - For State of Maryland / Dep	artment of Health and M rtificate of Death		ene () ()	
	Physicia		Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Y	3. Time of Death
	/Medic	al .	Natalie Mary Maloney	# 0° T	April	10 20 4c. County of	005 11:35 a <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number) 1101 Glasgow St.	4b. City, Town, or Location of Death  Cambridge			orchester
	F		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9	). Birthplace (State or Foreign
	Funeral Director		218–10–3339 <sup>1 M 25</sup> (F 86 Yrs.	Months Days Hours Min.	Month, Day, May		Country) Pennsylvania
	p.		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I	conting			10d. Inside City Limits
$\overline{}$	Maryland -f show fied at	_	10a. State 10b. County 10c. City, Town or I	Cambridge			1 MYes 2 □ No
$\prec$	he M	ecto	10e. Street and Number	10f. Zip Code	10	g. Citizen of Wh	at Country?
$\mathcal{Z}$	with with Lber	Funeral Director	1101 Glasgow St.	21613		USA	•
10	ns 23	era		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race -	American Indian,
ဖ	after or Item	Fur	1 ☐ Never Married 21又 Married 1 ☐ Yes 2 又 No	1 ☐ Yes 2 ☑ No Specify:	Hican, etc.)	Specify:	White, etc.
ဗ္ဗ	ural',	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:				white
<u>.</u>	"nat	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing	6b. Kind of Busi	ness/industry
21215-0036	i withi iene r than	mo	Elementary/Secondary (0-12) College (1-4or 5+)	homemaker		own h	ome
ק	il Hyg other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M	laiden Sumame)	
ylar	Menta Menta arkad atic a	To E	Camillo DeSantis	Julie	Mari		
Maryland	2 sho and Is ma			ing Address (Street and Number or Run			_
	1 and Health em 27 ther t		20a Method of Disposition 20b. Place of Disp	Glasgow St., Camb			ity or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic avent, the Medical Examinal must be notified at once.		1 M Burial 2 Cremation 3 Removal from State	Cemetery 4/1	5/05	Oxford	. MD
慧	ortan cortan			2. Name and Address of Facility Th			•
m	Departing any It	1	I fand lerson	700 Locust St., Ca	mbridge,	MD 21	613
ч			23a. Part1 Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition				DAYS
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	1110:10			1.
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8760,	ate be executed hysician and the burial-transit	lical	d.				
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Вох	atte for	Physician/Med	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of Month	
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	requires that the een signed by th hould be detache	by Pi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contrib	ute to the cause of death?
rds	v require been sig should b		OSkoorhritis Coronaly actery	Disease	1 ☐ Yes	s 2 000 3	☐ Probably 4 ☐Unknown
Vital Records,	as b	Completed	Gastroesophaseal Reflux Disco	se Peripheral	24a. Was an autopsy	/ pric	ore autopsy findings available or to completion of cause of
Œ	Th ate pag	Con	Vascular Disease	, 1	perform 1 Yes 2	yed? dea	ath? Yes 2000
Vita	Phyalcian: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Othor	h (Check only one		
ot	S P	- To	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time	ant 3 DOA 4 Industry He	me 5 Resider 28d. Describe how		
on	Attanding I r death. actor: After by the funer	tlon	1 → Patural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division	Attandi ar death. actor: A by the fu	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Str. City or Town,		or Rural Route Number,
	ital or rs afte al Dir	O					
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)  One	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the car red at the time, da	use(s) and mannite and place, an	ner as stated. d due to the cause(s)
	To the within 2 To the complet	Med	one) and manner stated.  29b. Signature and vittle of certifier	29c. License number	29	d. Date signed/	Month, Day, Year)
	F ≯ F ŏ		1 /pis al/a 12.0.	H44615	5	4/12/0	05
•			30. Name and address of person who completed cause of death (Item 23a) (Type			11-1	
			Luxs A. Nary D.O. 100 Bramble	St (Ambrio	ge MP	21613	3
	Sta Registi		31, Date filed (Month, Day Year) 1 3 20052, Register's Signature	Sports	-		
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		State of Man		rtment of Hea			0000	
		Registrar  1. Decedent's Name (First, Middle, Last)	Cer	uncate of De		Reg. 2. Date of Death	No.	3. Time of Death
Physici	an	111					Day Year	4 20 M
/Medic		4a. Facility Name (If not institution, give street and number)	15, 11.	4b. City, Town, or Lo	action of Dooth	7	4c. County of Death	1 1
Examin	er		shP.ILL			0 10 /0	Washi	as bia
	2.5	5. Social Security Number 6. Sex 7. Age (I	n yrs. last birthday)	If Under 1 Year If		8. Date of Birth		J
Funeral Director		168244769 18M 20F	T Y Yrs.	Months Days H	lours Min.	(Month, Day, Ye		place (State or Foreign htry)
344		Usual Residence of Decedent				1/10/-		14 13
yland		10a. State 10b. County 1	Oc. City, Town or Loc	cation				10d. Inside City Limits
Mar Hed	tor	Maryland Washington	Hage	erstown				1 ☐ Yes 2 🛣 No
INIU Z IZ 13-UU30 be filed within 72 hours after death with the Maryland hal Hygiene. id other than "natural", or itams 23a or 28e-f show avent, the Medical Experiment must be notified at	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	ntry?
23a		1745 Edgewood Hill Circle		2174		U	nited Stat	es
r dea	Funeral	11. Marital Status 12. Was Decedent Eve	er in U.S. 13. V	Vas Decedent of Hispa Yes, specify Cuban, N	nic Origin? (Spe Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
within 72 hours after ene. than "natural", or its the Medical Exemina	y F.	1 Never Married 2 Married 1 Yes 2 Mo If Yes, Give	†	_ **	Specify:		Specify: Whi	ite
ural', o	d by	3 Widowed 4 Divorced Year or Dates:						
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be filed with tal Hygiene id other than		17. Father's Name (First, Middle, Last)	Ma	naging 18	. Mother's Name	(First, Middle, Maid	Retail S	cores
ylaild build be file Mental Hy arkad oth attic aveni	) Be	Albert LeRoy Nichols, Sr.				Andrews 1		
aryicand ZIZ should be filed within and Mental Hygiene. s merked other then umetic event, the M	မ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and				Code)
d 2 sho d 2 sho th and th and traum		Beverly Ann Nichols (wife)		•				cyland 21740
ges 1 and 2 should to f Health and Mer If item 27 is marks or other traumatic			20b. Place of Dispos	sition (Name of			. Location - City or To	
Daltimore permit. Pages 1 Department of the fimportant: if ite any injury or ot one.		1 Burial 2 XCremation 3 Removal from State		natory or other place)		10 0E Cm	ithahımı N	formuland.
IKIIII artme artme ortan injury		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Furraral Service Licensee		g Cremator				
Depariment of the policy of th		1 ( ) amista Paulo		Name and Address of				
32133		23a. Part1. Enter the disease, or complications that caused in		31 Eastern		The second second	cowii Mary.	Approximate
		shock, or heart failure. List only one cause on each line.				toophiatory and only		Interval Between Onset and Death
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OO Ifficate p phy s the	edic	U.						
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death atte	clai	in the past 12 months?  1 ☐ Yes 2 ☐ No		Ectopic pregnancy Other (specify)			Month	Day Year
The Street	lys	9 Unknown						
GOIGS, P.O. BOX or requires that the death certific been signed by the attending p should be detached for use as	by Pi	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause given i	n Part I.	23e. Did tobacc	co use contribute to t	he cause of death?
w requires to been signer should be considered.						1 🗆 Yes	2 No 3 Pro	bably 4 Unknown
taw rec	Completed					24a. Was an	24b. Were auto	opsy findings available
VICAL KEC sician: The law s certificate has b lirector, page 2 s	m					autopsy	l? _ death?	opsy findings available impletion of cause of
VICAL ilcian: T certificat rector, pa	Ö	25. Was case referred to medical			R Place of Death	(Check only one)	Mo 1 ☐ Yes	2   No
OT VICA Physician: this certific ral director,	0 0	examiner?  1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatien				e 6 □Other (Speci	6.1
OT Phy or this eral d	H-	27. Mannarof Death 1 Natural 5 Pending (Month, Day Y			2	8d. Describe how i		(9)
on Th.: Afte	tloi	1 ☑Natural 5 ☐ Pending (Month, Day Y 2 ☐ Accident investigation	'ear) Injury		2 🗆 No			
DIVISION OF VITAL INC.  el or Attending Physicien: The Is affect death. It Director: After this certificate ha din by the funeral director, page	Certification:	3 Suicide 6 Could not be 28e. Place of Injury	- At home, farm, stre	eet, factory, office	2	8f. Location (Street	t and Number or Run	al Route Number,
d'in t	erti	4 Homicide determined building, etc.	Specify)			City or Town, S	tate)	
To the Hospitel of within 24 hours aff To the Funerel Discompletely filled in	alc	29a. Certifier 1 Certifying Physician: To the best of	my knowledge, death	occurred at the time,	date and place, a	and due to the cause	e(s) and manner as s	stated.
n 24 l n 24 l na Fu	edical	(Check only 2 Medical Examiner: On the basis of example) and manner state	xamination and/or inv	vestigation, in my opini	on, death occurre	ed at the time, date	and place, and due t	o the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier		29c. License ni			Date signed (Month,	Day, Year)
		> Jain mules		D001	60396	Ĉ	4/16/0	5
		30. Name and address of person who completed cause of dea	th (Item 23a) (Type,	Print) 1126	oral	COUY	+	
5H-6		30. Name and address of person who completed cause of deal FARID MUNSH	ED	14	neiston	n ~	0 217	40
	ate	31. Date filed (Month, Day, Year) 32. Registrar's	s Signature	1	)	7		
Regist	rar	APR 19 2005	J. B. A.	perted				

			1 - For Amend Item Registrar	23State of 19b per 1	Mary <b>8844</b> , 06 H	Partificate of	Health and N <i>Death</i>	nental Hygid Reg	ene 3. No 2 0 0 5	115
	Physici /Medic		1. Decedent's Name (First, Middle, L Alice	ast) Evangelir	ne NEWTON			2. Date of Death Month April 1	Day 2005	3. Time of Death
	Examir		4a. Facility Name (If not institution, g				or Location of Death		4c. County of Dea	
			Ravenwood Luthe		0	Hagers			Washing	
	Funeral Director		214-36-2201	.Sex 7 1 ☐ M 2 🖾 F	r. Age (In yrs. last birtho 96 Yrs	Months Dave		8. Date of Birth (Month, Day, Aug. 28)	9. Bir 1908 Wes	thplace (State or Foreign cuntry Virginia
	Maryland -f show	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland Washing	ton	10c. City, Town o					10d. Inside City Limits
	3a or 28a	i Direc	10e. Street and Number 1158 Luther Dri	ve	11	10f. Zip Code	21740	100	g. Citizen of What Co	ountry?
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, if a Medical Examinate nutilised at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	Armed Ford	2 🔼 No	13. Was Decedent of h If Yes, specify Cub		pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	filed within 72 he Hygiene. other than "natu	ompieted	15. Decedent's (Specify only highest s Elementary/Secondary (0-12)	Education grade completed)  College (3	(C	ecedent's Usual Occup live kind of work done fe. DO NOT use retire 'esearch	pation during most of work d)	ring	book publi	•
yland 2	12 should be filed within hand Mental Hygiene. 7 is marked other than "traumatic event, trains.	To Be C	17. Father's Name (First, Middle, La Rev. James		pert			e (First, Middle, Ma Edith L. ]		
	1 and 2 sho Health and I tem 27 is mu other trauma		19a. Informant's Name/Relationship Eleanor Westfall		At a see	ailing Address (Street Cabbage			City or Town, State, I t Virgini	
Baltimore,	t. Pa rtmen rtant:		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5 Other (Special Control of Contr	cify)		sposition (Name of crematory or other pla awn Memoria	ial Apri	il 22, <sub>H</sub>	oc. Location - City or agerstown Funeral H	, Maryland
Bal	Depariment of the permit of th		21. Signature of Funeral Service Lic	istist		22. Name and Addres				aryland 217
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	_aAl-	used the death. Do not ch line. Cerebro	Vascular	ng, such as cardiac Accident	or respiratory arres	it.	Approximate Interval Between Onset and Death 4 months
68760,	ficate be executed physician and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Entire denying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequence of)					
Box	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live bir	ome of pregnancy th 2 Fetal death int at time of death wn	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of del Month	livery Day Year
ds, P.O.	rires that t signed by d be deta		Part II. Other significant conditions	contributing to dea	ath but not resulting in th	e underlying cause giv	ven in Part I.	23e. Did toba		o the cause of death?
of Vital Records,	: The law requir cate has been si page 2 should	Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
ital		Be C	25. Was case referred to medical				26. Place of Deat	h (Check only one)		20.10
) (	Physician: this certific ral director,	To	examiner? 1 Tes 2 No		patient 2 ER/Outpa	atient 3□ DOA Oth	ner: 4 🖛 ursing Ho	me 5 Residen	ce 6 ⊡Other (Spe	cify)
	ding n. After fune		27. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident Investigat		f Injury 28b. Tim o, <i>Day Year)</i> Inju	ry Wo	ry at rk? Yes 2 □ No	28d. Describe how	injury occurred	
Division	e Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not determine	ad 286. Place	of Injury - At home, farm g, etc. <i>(Specify)</i>	, street, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Medical	29a. Certifier 1 Certifying (Check only one)	Physician: To the taminer: On the base and manner	pest of my knowledge, d sis of examination and/d er stated.	eath occurred at the ti or investigation, in my o	me, date and place, opinion, death occur	and due to the cau red at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	a 1	,	29c. Licens		1	d. Date signed (Mont	h, Day, Year)
)			manjen	g/L	ah		028365		4-15	00
<b>₹</b>	H-4		30. Name and address of person when y	Ma	1 368	pe, Print) WILL SN	ell- Al	agstar	4-13 m 170	21746
		ate	31. Date filed (Month, Day, Year)	32 Re	gistrar's Signature			)		

State Registrar Manyen 9
31. Date filed (Month, Day, Year)
APR 18

NEWTON, Alice Evangeline

DHMH 17 Rev 1/2001

**ORIGINAL** 

32. Registrar's Signature

			For Stata	State of Maryla		irtment of H			ene	n c	1 1 From 3 Jr.
			Registrar  1. Decedent's Name (First, Middle, Las	1)				2, Date of Death		سلياب	3. Time of Death
	Physici		John Ann	rew. Ne	vros			April	5,200	Year )5	1621 M
	/Medio Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County		
			Montgomery Gen			Olne			Mont	tgome	ery
	Funeral Director		5. Social Security Number 6. Se 172-24-8046	7. Age (In y	rs, last birthday) 2 Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) 2/25/1	913	9. Birthpl Count PA	lace (State or Foreign try)
	۵ >		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo	cation				11	0d. Inside City Limits
	ahov	5	MD. Montgo			r Sprin	q				1 ☐ Yes 2√2 No
	28a-f	Director	10e. Street and Number			10f, Zip Code		100	g. Citizen of V	What Coun	trv?
	3a or		14108 Aldertor	Road		20906	-2066		USA		
21215-0036	d within 72 hours after death with the Maryland Jiene. I than "natural", or Items 23a or 28a-f ahow The Medical Examinatinant ke inclined at	by Funeral	11. Marital Status  1   ↑ Nover Married 2 Married  3 Widowed 4 Divorced		24-	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S In, Mexican, Puert Specify:	pecify Yes or No- p Rican, etc.)		e - America ck, White, e /: Wh	
9	72 ho	Completed	15. Decedent's Ed	ucation	16a. Deced	lent's Usual Occup	ation	king 16	6b. Kind of Bu	usiness/Inc	Justry
21	within 7 lene. than "r	npie	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of NOT use retired	d)	King	IRS/	wal .	Gov't
2	illed will Hygier other th		47 5 4 1- 11- 11- 11- 11- 11- 11- 11- 11- 11	5+	At	torney	40 Markada Mar	ne (First, Middle, Ma			300 C
Maryland		To Be	17. Father's Name (First, Middle, Last) Andrew Nevro	S			Helen			re)	
	nd 2 sho alth and 27 Is mu		19a. Informant's Name/Relationship (7) Gus Nevros/Bro					ral Route Number, o			Code) , OH44136
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic events.		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	b. Place of Dispo cemetery, cren Baptis	sition (Name of natory or other place t Cemet	ery 4/1		ape M	ay C	wn, State ourtHouse Jersey
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Liven	M.	<b>P</b> 9	HTLTP*dD 241 Col	s RTWALD umbia B	I FUNER	AL SE	RVIC prin	E,P.A. g,Md20910
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	plications that caused the cone cause on each line.	leath. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arres	it,		Approximate Interval Between
	Pn <del>ysician</del>		Immediate Cause (Final disease or condition								Onset and Death
	/Medical		resulting in death)	Due to (or as a con	sequence of):	0 0		CANC	00		
E	Examiner		Sequentially list conditions,			4 KCh	PUFR	CANC	<del></del>		
	be tis	ine	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as a con	sequence of).						
	be executed sicien and burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or as a con	sequence of):						
8760,	cate be executed obysicien and the burial-transit	dicai E		d							5,000,000,000
687		edic		·							
Вох	eath certifi attending   for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy	,			te of delive	
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time 9 Unknown		Other (specify)			Mo	onth	Day Year
P.O	at the de I by the stached	Phys	9 Unknown						1		
Records,	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	by	Part II. Other significant conditions c	ontributing to death but not	resulting in the ui	nderlying cause giv	en in Part I.	1 ☐ Yes	4/		e cause of death? ably 4 □Unknown
တ္ထ	law re as bee 2 sho	Completed						24a. Was an autopsy			psy findings available inpletion of cause of
Ä	The la	E O						perform	ed?	death?	200
Vital	ı <b>lcian:</b> Th certificate rector, pag	Be (	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one,	)		
of V	Physician: this certific ral director,	2	1 Yes 2 10		2 ER/Outpatien		4   Nursing H	ome 5 Residen			)
		on:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	Wor	k?	28d. Describe how	r injury occur	red	
Sio	tan leat tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be		At home form at-		Yes 2 □ No	28f. Location (Stre	et and Numb	er or Rum	I Pouto Number
Division	or Attand after death Diractor: /	Certification:	4 Homicide determined	28e. Place of Injury - / building, etc. (Sp	ecify)	eet, ractory, onice		City or Town,		er or Hura	House Number,
	spital ours a neral filled		29a. Certifier Pertifying Ph	ysician: To the best of my	knowledge, death	occurred at the tir	ne, date and place	, and due to the cau	ise(s) and ma	anner as st	ated.
	To the Hospital or At within 24 hours after or To the Funeral Dirac completely filled in by	edicai		iner: On the basis of exam and manner stated.							
	To th Within To th compl	Me	29b. Signature and title of certifier	- /		29c. Licens	e number	29	d. Date signe	d (Month, I	Jay, Year)
	10		1500	13/101		D	0505	45	4/	6/0	) 5
	1		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print) GOD	SWILL	0.	DKO	31,	MO
			75 13 NEW	HAMESH	IRT AT	FME	TAKan	a vark	MD	200	>/2_
	Sta Regist	ite ar	30. Name and address of person who 31. Date filed (Month, Day, Year)  APR 1 3 20	7. Registrar's S	ignature dos	A STATE OF THE STA					
			LII 11 = 0 = -	NO THE PERSON NAMED IN	- /						

			1 - For State Registrar	State of Ma	aryland / Depa	artment of h		ental Hygie	4000	14517
			Decedent's Name (First, Middle, Last	st)	-			2. Date of Death	Day Year	3. Time of Death
	Physici /Medic		Joseph Fumio N					April 10		2:41 A M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of Deat	h
_			Holy Cross Hospi 5. Social Security Number 6. S		(In yrs. last birthday)	Silver If Under 1 Year		8. Date of Birth	Montgon	lery hplace (State or Foreign
ш	Funeral Director			M 2□F	85 Yrs.	Months Days	Hours Min.	(Month, Day, Ye Iav 9, 19	ar) Co	igan
	D D		Usual Residence of Decedent					1ay 9, 19	1.7 MICI	
	d within 72 hours after death with the Maryland liene. I then "natural", or Itams 23a or 28a-f ehow the Medical Examinar must be notified at	5	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	Director	Maryland Montgom	ery	Silv	er Sprin	g	100	Citizen of What Co	
	with	ā						Tog.		untry?
	ms 23	Funerai	4010 Ingersol Dri 11. Marital Status	12. Was Decedent 8	Ever in U.S. 13.		20902 dispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No-	USA 14. Race - Ame	
9	or Ital	F	1 ☐ Never Married 25 Married	Armed Forces? 1 ☐ Yes 2 ☑ N	lo			Rican, etc.)	Black, Whit	e, etc.
93	urat',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2√√2No	Specify:		Specify:	ian
5-	"natu	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of working	ng 16b	. Kind of Business/	Industry
12	within iene. than "	d mc	Elementary/Secondary (0-12)	College (1-4or 5	+)		<i>u)</i>	U.:	S. Patent	
9	Hys Hys ant,	a l	17. Father's Name (First, Middle, Last)		Solic	ltor	18. Mother's Name	(First, Middle, Maid	Trademar den Sumame)	k Office
<u>la</u> n	D D D	To B	William Noburo N	akamura			Elsie F	laruo Kuro	nk i	
Maryland 21215-0036	s m		19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address (Street	and Number or Rura			Tip Code)
	5 등 2 등		May T. Nakamura	Wi		Ingersol	Drive S	ilver Spi	ring, Mary	land 20902
Baltimore,	of of		20a. Method of Disposition  1  Burial 2  Cremation 3	Removal from State		matory or other pla	. D	ate 20c	. Location - City or	Town, State
Ħ,	tment tant:		* 4 □ Donation 5 □ Other (Specify			rematory	Apr.13	,2005 Ale	exandria,	Virginia
Baj	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licer	nsee S	Fr	ancis J.	Collins E	uneral Ho	ome, Inc.	
			23a. Part1. Enter the disease, or com	olications that caused	50	0 Univer	sity Blvd.	,W.,Silve	er Spring	,MD 20901 Approximate
	B		shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	ie.		19, 00011 00 001 0100 0	respiratory arrost,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		lerosis He a consequence of):	art and '	Vessel Dis	ease		
	Examiner				a consequence or,					
	صِ	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of).					
	ocuted nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
30,	death certificate be executed attending physician and of for use as the burial-transit		resulting in death) Last	Due to (or as	a consequence of):					
8760,	cate b physic	Physician/Medical		d						
9 X	eath certific attending p I for use as 1	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of del	non.
Вох	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at		Ectopic pregnance Other (specify)	у		Month	Day Year
0.	at the de by the a	hysi	9 Unknown	9□ Unknown						
S, D	The law requires that the tte bas been signed by thogge 2 should be detache	by P	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tobaco	co use contribute to	the cause of death?
Records,	w require been sig should b							1 🗌 Yes	2 No 3 Pr	obably 4X Unknown
ecc	law r as be	Completed						24a. Was an autopsy	prior to o	topsy findings available completion of cause of
E E		Con						performed 1 ☐ Yes 2√☐	l?   death?	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0#	26. Place of Death	(Check only one)		
of	Phys	To	1 X Yes 2 No 27. Manner of Death	1 Inpatie	nt 2 ☐ ER/Outpatie	IL SELLOW		ne 5 Residence		cify)
O	ding P th. After funera	tion	1 XNatural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	Wo	rk? Yes 2 □ No	od. BodonBo now ii	njury occurros	
Division	or Attending after death. Director: After in by the fune	ertification;	3 Suicide 6 Could not b	e 28e. Place of Inju	ury - At home, farm, st	reet, factory, office	2	8f. Location (Street	t and Number or Ru	ral Route Number,
ā	tal or At s after d al Direct ed in by	Cert	4   Normalde	building, et	c. (Specify)			City or Town, S	rate)	
	Hospital 24 hours a Funeral L tely filled	edical (	29a. Certifier 1 Certifying Ph (Check only 2 Medicel Exer	ysicien: To the best	of my knowledge, deat examination and/or in	h occurred at the til	me, date and place, a	nd due to the cause	e(s) and manner as	stated.
	To the Hos within 24 h To tha Fur completely	Medi	one)	and manner sta	ated.					
		-	29b. Signature and title of certifier	1	10 //	29c. Licens			Date signed (Monti	
	3		30 Name and address	nce VI	1 Juffer		10010	1424	4-12	05
			30. Name and address of person who		*****	,	ond Cii	ose C	. M	1 20010
	Sta	ate	Lawrence A. Oufi 31. Date filed (Month, Day, Year)	32 egistra	ar's Signature	st Gien I	wau SILV	er spring	, Mary Land	1 /0910
	Regist		APR 14 2	2005 Some	w st. Pf	A STATE OF THE STA				

		1- Stete Registrar amend item		Maryland / De				nd M	ental Hy	gien Reg. N	00		11 5 10
Physicia	an	Decedent's Name (First, Middle, Las	it)						2. Date of De Month	Da	ay	Year	3. Time of Death
/Medic	al	Bridie  4a. Facility Name (If not institution, give	a atract and numba	O'Donne	_	h. Town or	Location of		April	_	2005 c. County o	of Death	1:28 P M
Examin	er	Suburban Hospita		"/	40.0		esda	Death			Montg		v
Funeral		5. Social Security Number 6. S	ex 7. A	age (In yrs. last birthda	y) If Un Month	der 1 Year	If Under 24	4 Hrs. Min.	8. Date of Bir (Month, Da	th	T		lace (State or Foreign
Director		3/0-00-090/	□ M 2⊠F	97 Yrs.		Buyo	Tiours		oct. 5.	-			ern Irelan
Mo T		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location							10	0d. Inside City Limits
a-f sh iffed	tor	Md. Montgo	nery	German	town								1⊠Yes 2□No
or 284	Sirec	10e. Street and Number			10f.	Zip Code				10 <b>g</b> . C	itizen of W	hat Coun	try?
s 23a	ral	13231 Anthum Mist				208					S.A.		
d other then "neturel, or tems 23s or 28s+ show event, the Medical Exercitival be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	5? ] No	If Yes, s	cedent of Hi pecify Cuba 2 12 No	spanic Origir n, Mexican, I Specify:	n? (Spec Puerto F	cify Yes or No Rican, etc.)	)- 		- Americ , White, (	
lical E		15. Decedent's Ed		16a. De	cedent's U	sual Occupa	ation furing most o	of commercia		16b. h	Kind of Bus		
Med A	Completed	(Specify only highest gra	College (1-4o	life	DO NO	use retired	)	SI WUIKIII	9				
other then ent, If e M		8 17. Father's Name (First, Middle, Last)		He	ome M	aker	19 Mother's	o Nomo	(First, Middle	Maida		Home	!
C evel	o Be	Owen Muckian							: Mucki		Jumame	"/	
le marked creumetic ever	7	19a. Informant's Name/Relationship (7	ype, Print)	19b. Ma	iling Addre	ess (Street a			Boute Numb		or Town, S	State, Zip	Code)
1 27 le er tre		Mary E. Beck/Daug	nter				OCEAN						
in the last		20a. Method of Disposition 1   ■ Burial 2 □ Cremation 3 □	Removal from Stat	20b. Place of Dis	position (frematory	lame of r other place	9)	Da	ate	20c. L	ocation - C	City or To	wn, State
jury		`4 ☐ Donation 5 ☐ Other (Specify	2	Gate of					14,05				ng,Md.
Important: If item 27 le marked any injury or other treumetic ev once.		21. Signature of Funeral Service Ligen	ell .		2222	Wisc.	Ave.	, N.	ol Fun W. Was	h.D.		_	
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that cause one cause on each	ed the death. Do not e line.	nter the m	ode of dying	g, such as ca	ardiac or	respiratory a	rrest,			Approximate Interval Between Onset and Death
ician dical		Immediate Cause (Final disease or condition resulting in death)	w	dial Infar	ction	1							
iner		(	Septic	s a consequence of):									
	Jer	Sequentially list conditions, if any, leading to immediate	U	s a consequence of):									
transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
the burial-transit	I Ex	resulting in death) Last	Due to (or a	s a consequence of):									
d eu	dical		d										
for use as	<b>w</b>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					-			23d. Date	of deliver	v
tached for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre <i>g</i> nant		☐ Other	pregnancy (s <i>pecify</i> )					Mont		Day Year
	hys	9 🗆 Unknown	9□ Unknown										
p eq	by	Part II. Other significant conditions of	ontributing to death	but not resulting in the	underlying	g cause give	n in Part I.						e cause of death?
should	eted												ably 4 🛣 U⊓known
10.2	Completed								24a. Was autor		pri	ere autop ior to com ath?	sy findings available apletion of cause of
rector, page	e Co	25. Was case referred to medical					06 Plans of	4 Dooth	1 Yes	2 🔀 No		Yes	2 No
	0 B	examiner?	Hospital:	tient 2 ER/Outpati	ent 3 🗆 I	Och Othe			(Check only o		6 Other	(Specify	1
neral	T:u	27. Manner of Death	28a. Date of In (Month, D	jury 28b. Time	of	28c. Injury Work			3d. Describe I				/
ed in by the funeral d	atic	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	М		es 2 □No	)					
n by t	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of II	njury - At home, farm, setc. (Specify)	street, fact	ory, office		28	Bf. Location (S City or Tox			or Rural	Route Number,
pelli	0	29a. Certifier 1 → Certifying Ph	veicies: To the box	t of my knowledge, de	nth a nausa	سند مطعما		-1000 00	ad due to the		\ a.a.d		
etely	edical	(Check only one)	iner: On the basis and manners	of examination and/or	investigati	on, in my op	inion, death	occurre	d at the time,	date an	d place, an	id due to	the cause(s)
completely filled in	Me	29b. Signature and little of certifier			2	9c. License	number			29d. Da	te signed (	(Month, E	Pay, Year)
						D006	1302			Ap	ril 1	1, 2	.005
2		30. Name and address of person who					1						
		Atul Rohatgi, M.I	2300 E	ye St., N.	W. Wa	shing	ton, D	).C.	2003	37			
Sta Registra		Atul Rohatgi, M.I 31. Date filed (Month, Day, Year) APR 1 4 2	005 327 legis	trars signature	Carl.								

		Fav	State of Marylar	nd / Depart	ment of Health	h and M	ental Hva	iene	
		1 - State Registrar	,		icate of Deat			g. No. 0 0 5	14519
D1		1. Decedent's Name (First, Middle, Last					2. Date of Deat Month		3. Time of Death
Physic /Med		Christine Marie P	antaleo				April 1	2005	11:40 P M
Exam	iner	4a. Facility Name (If not institution, give			o. City, Town, or Location	on of Death		4c. County of E	eath
<b></b>		Montgomery Hospic  5. Social Security Number 6. Se			Rockville Underlyear If Und	der 24 Hrs.	8. Date of Birth	Montgo	mery Birthplace (State or Foreign
Funera Directo			M 2QF 59	Yrs.	onths Days Hour	rs Min.	(Month, Day,	Year) 8,1946 No	Country)
pu »		Usual Residence of Decedent  10a. State 10b. County		ty, Town or Locati				0,1740  10	
ith the Marylan or 28a-f show	5	,			on				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the h	Director	Maryland Montgome:	ry	01ney	10f. Zip Code		11	0g. Citizen of Wha	
3a or	Ö	/101 Ch - 11 P1	T			0.0			, oodiniy i
death	Funeral	4101 Shallow Broot	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was	2083 Decedent of Hispanic es, specify Cuban, Mexic	Origin? (Spec	cify Yes or No-		merican Indian,
s after	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 💽 No If Yes, Give		Yes 212 No Spec		iloan, otc.)	Specify:	Vhite, etc.
ified within 72 hours after death with the Maryland Hygiene.  Ther then "naturel", or Items 23e or 28e-f show ent, the Medical Example or must be multipled at	ed b	3 Widowed 4 Divorced	Year or Dates:	16a Deceden	's Usual Occupation				White
nin 72	Completed	(Specify only highest grad		(Give kin	d of work done during m NOT use retired)	nost of workin	g	16b. Kind of Busine	ass/modstry
d with giene green	E O	Ciementary/Secondary (0-12)	2	Executi	ve Assistar	nt		Communic	ations
be file	Be (	17. Father's Name (First, Middle, Last)					(First, Middle, N	Maiden Surname)	
Idi yidild 212 2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Ma	မ	Alexander Vinck		1		Rose	Stumbi	A T 1000	
d2st d2st thanc 17isn traun		19a. Informant's Name/Relationship (T)			ddress (Street and Nun				
tem 27		John Pantaleo, Jr 20a. Method of Disposition	206. i	Place of Disposition				Mary 1an 20c. Location - City	
Pages tment of hand in It Ite	,	1 ☑ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State A1	cemetery, cremato 1 Souls	Cemetery	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	2005		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-1 show any jury or other traumatic event, the Martical Examinactinust Le multiple and any jury or other traumatic event, the Martical Examinactinust Le multiple and any or other traumatic event, the Martical Examinactinust Le multiple and any or other traumatic event, the Martical Examinactinust Le multiple and any or other traumatic event, the Martical Examinactinust Le multiple and any or other traumatic event, the Martical Examinactinust Le multiple and any or other traumatic events.	å l	21. Signature of Funeral Service Licens	199	22. N	ame and Address of Fa	acility			n.Maryland
<b>0</b> &ă <b>5 5</b>	3	/Leberte Ka	amsly						ng,MD 20901
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that sed the dea ne cause on each line.	th. Do not enter t	ne mode of dying, such	as cardiac or	respiratory arre	est,	Approximate Interval Between
Physician	_	Immediate Cause (Final disease or condition resulting in death)	Metastatic		a				Onset and Death month
/Medica Examine		1	Due to (or as a consec						
	je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Non Small C Due to (or as a consec		er of Lung				1 year
cuted nd ransit	Examiner	that initiated events	:						
cate be executed only sician and the burial-transit	EX	resulting in death) Last	Due to (or as a consec	quence of):					
physic physic the b	dicai		1						
death certifical attending ph	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn	ancy				23d. Date of	deliver
death death d for u	Iclar	in the past 12 months?	1☐Live birth 2☐Feta 4☐Pregnant at time of c		topic pregnancy her (specify)			Month	Day Year
The law requires that the death certificate are has been signed by the attending physpage 2 should be detached for use as the	Physician/Me	9 🗆 Unknown	9□ Unknown						
res tha	by	Part II. Other significant conditions co.	ntributing to death but not re-	sulting in the unde	rlying cause given in Pa	art I.			e to the cause of death?
w require been si should	Completed						1 <u>X</u> Ye	s 2∐No 3[	Probably 4 Unknown
e law	m jd						24a. Was ar autopsy perform	y prior	autopsy findings available to completion of cause of
raiclan: The law s certificate has t	ပိ	25. Was case referred to medical					1 ☐ Yes 2	₩ No 1 □	
Attending Physician: or death. ector: After this certific by the funeral director,	O	examiner?	fospital: 1 Inpatient 2	ER/Outpatient	0.1		(Check only one		Specify)Hospice
ng Ph ter th	T: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?			w injury occurred	nospice
tending eath. or: Afte	catic	2 Accident investigation			M 1 ☐ Yes 2				
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific: completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, street, fy)	factory, office	2	8f. Location (Str City or Town	eet and Number of State)	Rural Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier 1 XCertifying Phy	sicien: To the best of my kn	owledge, death or	curred at the time, date	and place, a	nd due to the ca	use(s) and manner	as stated
n 24 h n 24 h he Fu	edical	(Check only 2 Medical Exemi	ner: On the basis of examination and manner stated.	ation and/or inves	igation, in my opinion, o	death occurre	d at the time, da	ite and place, and	due to the cause(s)
To the comp	Σ	29b. Signature and title of certifier	P:0		29c. License numbe	er	29	d. Date signed (M	onth, Day, Year)
14		P. C. P.	Libri		D09470		Ap	ril 12,	2005
[6		30. Name and address of person who co			•	77		ID 0000	
s	tate	Eugene P. Libre, N	1. D. 10901 ( 32 Registrar's Sign	Connecti appro	cut Avenue	Kensi	ington,	MD 20895	
	trar	ΔPR 1 4 20	05   4	17. GOBA					

			1 - State of Mary Registrar		artment of H			iene ag. No. 0	5 14	520
П	Physici	an	1. Decedent's Name (First, Middle, Last)  Rondomin Honding DARTH	TDOE To			2. Date of Dea Month		Year 3. Tim	e of Death
	/Medic	al	Benjamin Waring PARTR  4a. Facility Name (If not institution, give street and number)	IDGE, Jr.		r Location of Deat		12, 2005 4c. County		5:30A <sup>M</sup>
	Examin	er	Washington Adventist Hospital	1	Takoma		п		gomery	
	Funeral Director		236-62-0922 1\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9,1915	9. Birthplace (Sta Country) West Vir	te or Foreign ginia
	land ow			c. City, Town or Lo	ocation				10d. Insid	e City Limits
	B-f sh	tor	MD Montgomery	Takoma	Park					res 2□No
	h with the 23e or 28	Funeral Director	10e. Street and Number 411 Tulip Ave.		10f. Zip Code 2091	2	1	0g. Citizen of W		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23e or 28a-f show eny injury or other treumatic event, the Medical Exact and Lear celling at one.	by Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever Armed Forces?  1 Ves 2 No V 10 Ves Cive Ves Cive Ves Conductions of the conduction	rin U.S. 13. V AWII Orean et Nam	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	specify Yes or No- to Rican, etc.)	Black	- American Indian K, White, etc. White	1,
Baltimore, Maryland 21215-0036	rithin 72 ho ne. han "natur he Medical	Be Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12) College (1-4or 5+)	16a. Deced (Give life. L	dent's Usual Occup kind of work done DO NOT use retired	during most of wo d)	rking	16b. Kind of Bu		
2	Higed w Hygier ther th	Cor	17. Father's Name (First, Middle, Last)	Capta	inLawy		ma (First Middle I	U.S. N		
yland	nould be I	To Be	Benjamin Waring Partridge			May A	me (First, Middle, M Asbury			
, Mai	and 2 sh ealth and m 27 Is n	В	19a Informant's Name/Relationship (Type, Print) enjamin W. Partridge, III / so	on P.O.	Box 267	and Number or Au , St. Tho	omas, Vir	gin Isl	State, Zip Code) and, 008	04
more	Pages 1 nent of H ant: If Ite			20b. Place of Dispo cemetery, cren Metropoli	matory or other place	atory Api			City or Town, State andria,	
Balt	permit. Departr Importe eny inji		21. Signature of Finance Licensee	22	2. Name and Addre	ss of Facility Ton	chinsky	Hebrew	Funeral	
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause/on each line.	death. Do not enti-	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approxir Interval	nate Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	monic					Onset a	nd Death
ı	Examiner		Due to (or as a co	nsequence of):						
	p ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	insequence of):						
o,	cate be executed obysician and the burial-transit	Examiner	that initiated events resulting in death) Last C Due to (or as a co	nsequence of):						
68760	ficate be physicials the bu	edical	d							
O. Box	The law requires that the death certifics are has been signed by the attending phoage 2 should be detached for use as to	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day	Year
rds, P.	w requires that been signed b should be det	þ	Part II. Other significant conditions contributing to death but no	at resulting in the un	nderlying cause giv	en in Part I.		_	oute to the cause of	
Vital Records,	Physicien: The law rethis certificate has bee	Completed	Hypothymo, carci	noma	pristo	ru	24a. Was ar autops perform	y pr ned? de	ere autopsy findin ior to completion o eath?	gs available if cause of
Ta .		BeC	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one		JYes 2□No	
Division of V	to the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	2	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Ye.	2 ER/Outpatient 28b. Time of Injury	28c. Injun Worl	/ at </td <td>ome 5 Reside</td> <td></td> <td></td> <td></td>	ome 5 Reside			
INISI	or Atten fter deat director: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - building, etc. (S)	At home, farm, stre		Yes 2 □ No	28f. Location (Str City or Town	reet and Number , State)	r or Rural Route N	umber,
_	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the tuner.	edical Ce	29a. Certifier (Check only one) Medical Examiner: On the basis of examiner and manner stated.	y knowledge, death imination and/or inv	occurred at the time vestigation, in my of	ne, date and place pinion, death occu	, and due to the ca	use(s) and man	ner as stated.	9(s)
	To the within To the comple	Mec	29b. Signature and title of certifier		29c. License				(Month, Day, Year	
	ما		fluillim		1) 25	5009		april	12 200.	1
	1		30. Name and address of person who completed cause of death Pamela Mulshine, MD 10801 Loc	(Item 23a) (Type, R kwood Dr.	Print) Silver	Spring,	MD 20901		(	
	Sta Registr	4.1	31. Date filed (Month, Day, Year) APR 1 4 2005	Signature Appa	els)					

		1 - For State Registrar	State of Maryla		rtificate of			. No. 2 0 0	5 1452
Physic /Medi	ċal	Decedent's Name (First, Middle, Las  Luna Maud Powis  As Equilibrium (If set institution sing			th Cit. Taur		2. Date of Death Month	Day Yea	6:25 a. <sup>N</sup>
Funeral	ı	4a. Facility Name (If not institution, give  9007 Linton Street  5. Social Security Number  6. Se	ox 7. Age (In yrs	. last birthday) Yrs.	Silver So If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	Montgomery (ear) 9. B	irthplace (State or Foreig Country)
Director -1 show		589-59-2357		ity, Town or Lo			Oct.20,1	933   Jar	naica 10d. In <i>s</i> ide City Limits 1 □ Yes 2√∑ No
ath with the s 23a or 28a	ral Director	10e. Street and Number 9007 Linton Street			10f. Zip Code 2090 I			D. Citizen of What C	
s within 72 hours after death with the Maryland siene. Then "naturel", or items 23a or 28a-1 show the Wolcal Examiner must be notified at	d by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, nite, etc. Lack
d within giene. or than "	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		16a. Deced (Give life.		ation during most of workir d)	ng 16	Own Home	
be file	To Be C	17. Father's Name (First, Middle, Last)  Arnold Taylor  19a. Informant's Name/Relationship (7)	ivna Print)			18. Mother's Name  Rachael  and Number or Rura	David	iden Sumame) SON	
of Hear		Pauline A. Salmon  20a. Method of Disposition  1 🗷 Burial 2 □ Cremation 3 🖾	Daughter 20b.	9007 Place of Dispo	Linton St sition (Name of matory or other place	reet Sil	ver Spri		20901
permit, Pag Department Importent: I eny injury o		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	/	Fr	e Memoria Park Name and Addre ancis J. OO Univer	Apr. 23 ss of Facility Collins F	uneral Ho	. Laudero	
Physician /Medical		23a. Part1. Anter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	offications that caused the dearne cause on each line.  a. Ovarian Can Due to (or as a conse	th. Do not ent	er the mode of dyin	g, such as cardiac o	r respiratory arrest	, ,	Approximate Interval Between Onset and Death 3 yrs.
e be executed risician and burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to [or as a consect.  Due to (or as a consect.	uence of			,		
the death certificate y the attending phy: Iched for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ XNo 9 □ Unknown	d	al death 3	Ectopic pregnancy			23d. Date of d Month	elivery Day Year
The law requires that te has been signed b page 2 should be deta	ρχ	Part II. Other significant conditions co	entributing to death but not re-	sulting in the u	nderlying cause give	en in Part I.			to the cause of death?  Probably 4 Unknow
	Completed	25 W.					24a. Was an autopsy performe	d? prior to death?	autopsy findings available completion of cause of as 2 No
ing Phye	ation; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2  Accident investigation	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injun Worl	26. Place of Death  er: 4 \sum Nursing Hom  / at 2  Yes 2 \sum No	The second secon		ecify)
B Hospitei or Attendi 24 hours after death B Funerel Director; 4 etely filled in by the fi	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Speci	(fy)			City or Town, S	State)	Rural Route Number,
To the Hosp within 24 hou To the Funel completely fil	Medical	29a. Certifier (Check only one)  1 ★ Certifying Phy 2 ★ Medical Examone)	rsician: To the best of my kni iner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the time vestigation, in my of 29c. License	oinion, death occurre	d at the time, date	se(s) and manner a and place, and du Date signed (Mor	e to the cause(s)
		200. Signature and the or Bittier	eleo		D 29			oril 12,	
3		30. Name and address of person who o				17 <u>6</u>		7211 129	2003

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 130PM 2005 , ra /Medical c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner albot treet 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 18-873 Months Min 1 □ M 2 1 F Days Hours Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nnent of Heath and Mental Hygiene.
and: If item 27 Is marked other than "natural", or Itema 23a or 28a-f show try or other traumatic event, I're McAlcul Ex. other must be millind at mry or other traumatic event, I're McAlcul Ex. other must be millind at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 1 Yes 2 □ No Director ON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 60 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: Black 3 ☑ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) sekee Per Residence 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 10 Milliam 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21601 19a. Informant's Name/Relationship (Type, Print) August Easton, Maryland bson IV 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or of once. 1 1 Burial 2 □ Cremation 3 □ Removal from State Screamers Ville Conder Oxford 105 <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Family HENRY FUNERAL A 510 Washington 21. Signature of Funeral Service Licensee Home, MD. 21613 STIC 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate Interval Between Onset and Death Immediate Cause (Final Syears Physician disease or condition resulting in death) -wne /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner certificate be executed burial-transit attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

of or Attending Physician: after death. Director: After this certifica funeral

Certification;

Medical

1 Natural 2 Accident

3 Suicide

29b. Signature and title of certifier

filled in by To the Hospital o within 24 hours aff To the Funeral Di

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

5 Pending

investigation

1 ☐ Yes 2 ☐ No

21601

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

State Registrar

Dr. Mary DeShields, 509 Idlewild Ave., Easton, MD 2005 Registrar's Signature 31. Date filed (Month, Day,

Injury

			1 - For Amend Item 2	State of Maryl	and Dep	artment of He 09/05dhb rtificate of L	ealth and M Death	ental Hygi	iene g. No 200	5 14523		
	Physicia	20	1. Decedent's Name (First, Middle, Las	1)				2. Date of Death Month	n Day Ye	3. Time of Death		
	/Medic		LeRoy Louis Pape					April	14 20 4c. County of D			
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death					
	Euporal		3244A Conowingo 5. Social Security Number 6. Se		rrs. last birthday)	Street If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Dey,	Harfo	Birthplace (State or Foreign		
	Funeral Director		218-24-8138	<b>X</b> M 2□ F	75 Yrs.	Months Days	Hours Min.	Sept. 2	1, 1929	Maryland		
	pu »		Usual Residence of Decedent  10a. State 10b. County	10c	City, Town or Lo	ocation				10d. Inside City Limits		
	faryla show	ō				Journal of the Control of the Contro				1 ☐ Yes 2 No		
	286-1	Director	Maryland Harfo	ra	Street	10f. Zip Code		10	ng. Citizen of What	Country?		
	3a or	Ī	3244A Conowingo	Road		9	1154		USA			
	death	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe	cify Yes or No-	14. Race - A	merican Indian, /hite, etc.		
9	or ite		1 Never Married 2 Married	1 Yes 2 No		1 ☐ Yes 2 Ø No	Specify:	Tiodii, 6(c.)	Specify:			
5-0036	72 hours after death with the Maryland natural', or items 23s or 28e-f show disal Examiner must be notified at	Completed by	3 X Widowed 4 □ Divorced	Year or Dates: 195	1-53		tian.			White		
45	- 35	olete	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of workii	t of working 16b. Kind of Business/Industry				
2121	filed within Hygiene. other than "ent, the Mes	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		ress Owner			Drywa	ll		
٦	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other than "natural", or items 23a or 28e-1 show is marked other than "natural", or items 20a or 28e-1 show eumatic event, it is Medical Examinar must be notified at	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name	•	*			
<u>/lar</u>	2 should be f and Mental b is marked of reumatic ever	10 E	John Dietrich Pa	pe			Elean	or Louis	e Niner			
Maryland	nit. Pages 1 and 2 should artment of Health and Mer ortant: If item 27 is marke injury or other treumatic 8.		19a. Informant's Name/Relationship (7	ype, Print)		ng Address (Street a			•			
	1 and 2 Health tem 27 i		Joseph Pape/Son  20a. Method of Disposition	20		6 Saybrook position (Name of			na, MD 2			
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr onca.		1 X Burial 2 ☐ Cremation 3 ☐	removal from State		osition (Name of matory or other place	. 1					
퍮	permit. Page Department of Important: If any injury or once.	2	<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service Licen</li> </ul>	ardens 4- s of Facility			Maryland					
Ba	Departiment of the particular		21. Signature of Funeral Service Licensee  22. Name and Address of Facility R. T. Foard Funer 111 South Queen S						P.A.	ND 21011		
			23a. Part). Enter the disease, or comp shock, or heart failure. List only	plications that caused the consequence	ieath. Do not en	ter the mode of dying	, such as cardiac o	r respiratory arre	est,	Approximate Interval Between		
Į.	Pnysician	8 T	Immediate Cause (Final disease of condition		Aspira	tion Ter	minal			Onset and Death 3 days		
	/Medical		resulting in death)	a. Due to (or as a con	sequence of):	VI0				-		
	Examiner		Sequentially list conditions,	b. severe c	ervical	arthretis				5 years		
U	sit s	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or se a son		. A =+1	-			20 years		
di.	and and i-tran	Examin	that initiated events resulting in death) Last	c. Severe Due to (or as a con		uid Arthri	rts			) ,		
8760,4	cate be executed physician and the burial-transit	aiE		4								
687	ificate g phy: as the	edicai		. U.								
Вох	n cert anding use a	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		⊒Ectopic pregnancy			23d. Date of			
	Physicien: The law requires that the death certific this certificate has been signed by the attending pr ral director, page 2 should be detached for use as	by Physician/Me	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at time		Other (specify)			Month	Day Year		
P.0	at the	Phy	9 Unknown				a in Part I	220 Did toh	agga uga gagtribut	e to the cause of death?		
	res th	þ	Part II. Other significant conditions of Sei Fure &.	· -	resulting in the t	ingeriying cause give	nın Panı.			Probably 4 Unknown		
9	w requir been si should	Completed	7011010 01	301 6 6				-				
36	nelaw hasl	mpi						24a. Was ar autops perform	y prior ned? deat	autopsy findings available to completion of cause of h?		
<u>=</u>	n: Th	ပိ	25. Was case referred to medical				26. Place of Death		1 \( \)	Yes 2□No		
<b>=</b>	ysicle s cert direct	To B	examiner?	Hospital: 1 ☐ Inpatient			nce 6 Other (5	Specify)				
0	g Phy ter thi	T:U	27. Manner of Death	28a. Date of Injury (Month, Day Yea	at ?	28d. Describe ho	w injury occurred					
Sio	endin sath. or: Af he fur	atic	Natural 5 Pending investigation		r) Injury		res 2 □ No					
Division of Vital Records,	or Atter de irecte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, st pecify)	reet, factory, office		28f. Location (Sti City or Town		r Rural Route Number,		
	orsal orsal aret D	Ce	Continue Bh	relains. To the best of my	Ivanulada, da	Manager of all the Alexander	, data and slags	and due to the or	uso(s) and mann	r or stated		
	24 hos 24 hos Fun etely 1	Medical	29a. Certifier	ysician: To the best of my niner: On the basis of exame and manner stated.	mination and/or in	nvestigation, in my op	pinion, death occurre	ed at the time, da	ate and place, and	due to the cause(s)		
	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has a completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier			29c. License		25	9d. Date signed (M	onth, Day, Year)		
			> perhet the			20004	2050		4/14/05			
	30x1/4	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
	7	Prashant Shukla, MD 15 S. Parke Street # 400 Aberden No 21001										
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 5 200	39. Registrar's S								

/sician ledical				Certificate	e of Death	F	giene 0 0 5	14024
ledical	1. Decedent's Name (First, Mic	ddle, Last)		)		2. Date of Dea Month	Day Year	3. Time of Death
	Flare		10	200		April 2	2, 2005	11:33 A
miner	4a. Facility Name (If not instituted to the second	-	mber)	1	Fown, or Location of Death Frederick		4c. County of Dea	ath ederick
eral ctor	5. Social Security Number 214-10-1614	6. Sex 1 □ M 2½ F	7. Age (In yrs. las 93	t birthday) If Under Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth April 2	25';°1911 9. Bi	inthplace (State or Forei Maryland
	Usual Residence of Decedent 10a. State 10b. Cour		10c City	Town or Location				10d. Inside City Limi
ctor	Maryland	Frederick		Fre	ederick			1 X Yes 2 □ N
Funeral Director	10e. Street and Number 615 Magnolia	Avenue		10f. Zip	21701		10g. Citizen of What C	U.S.A.
ner	11. Marital Status	12. Was Dec Armed F	edent Ever in U.S.	13. Was Deced	ent of Hispanic Origin? (Spirity Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
Ď	1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divord	Married 1 ☐ Yes	2 □ No	1 □ Yes		,,		hite
Completed	15. Decec (Specify only hig Elementary/Secondary (0-12	dent's Education phest grade completed) College (		16a. Decedent's Usua (Give kind of wor life. DO NOT us	I Occupation k done during most of work e retired)	ing	16b. Kind of Business	s/Industry
, i	11			Homemal	ker		Own Hom	ne
0	17. Father's Name (First, Midd						Maiden Surname)	
ဥ	Allen T. Wac	hter			Virginia	Green		
once. To E	19a. Informant's Name/Relation A. Irvin Renn			_	(Street and Number or Rura nolia Avenue,		-	
	20a. Method of Disposition  1   ☐ Burial 2 ☐ Crematic  4 ☐ Donation 5 ☐ Other	on 3 Removal from	20b. Place Cent State Mount	ce of Disposition (Nametery, crematory or of ULIVET CEI	ne of ther place) metery April	25, 200	20c. Location - City o	r Town, State
an al er	23a. Part1. Enter the disease shock, or heart failure. Limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aDue to	caused the death. e ch line. (or as conseque) (or as a conseque)	Do not enter the mode of):	& Basford Fust Church Str	cet From respiratory ar	ederick, M	T 21701 Approximate Interval Between Onset and Death
sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live	itcome of pregnance birth 2 ☐ Fetal de nant at time of deal	eath 3□Ectopic pr			23d. Date of de Month	alivery Day Year
by Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live 4 ☐ Preg 9 ☐ Unkr	birth 2 Fetal denant at time of deal	eath 3 ☐ Ectopic printh 5 ☐ Other (spining in the underlying call	ecity)		Month	Day Year to the cause of death?
by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live 4 ☐ Preg 9 ☐ Unkr	birth 2 Fetal denant at time of dear	eath 3 ☐ Ectopic printh 5 ☐ Other (spining in the underlying call	ecity)	1 □ Y	Month  bacco use contribute in the set of th	Day Year to the cause of death? Probably 4 Unknov
completed by Physician/Mec	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live 4 ☐ Preg 9 ☐ Unkr	birth 2 Fetal denant at time of deal	eath 3 ☐ Ectopic printh 5 ☐ Other (spining in the underlying call	ecity)	1 U Y	Month  bacco use contribute the set of the s	Day Year to the cause of death? Probably 4 Unknow autopsy findings available completion of cause of
completed by Physician/Mec	23b. Was decedent pregnant in the past 12 months?  1	1 ☐ Live 4 ☐ Preg 9 ☐ Unkr	birth 2 Fetal denant at time of deal	eath 3 ☐ Ectopic printh 5 ☐ Other (spining in the underlying call	ecity)	1 Yes	Month  bacco use contribute ties 2 No 3 F  an 24b. Were a prior to death? 2 No 1 Ye	Day Year to the cause of death? Probably 4 Unknow autopsy findings available completion of cause of
o Be Completed by Physician/Mec	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant cond	1 □ Live 4 □ Preg 9 □ Unkr  ditions contributing to co	birth 2 Fetal de nant at time of deal nown  death but not resulti	eath 3 Ectopic printh 5 Other (spining in the underlying call	ause given in Part I.  ORIGINATION  26. Place of Death	24a. Was autop perfor 1 Yes	Month  bacco use contribute ties 2 No 3 F  an 24b. Were a prior to death? 2 No 1 Ye	Day Year  to the cause of death?  Probably 4 Unknow autopsy findings available completion of cause of
To Be Completed by Physician/Mec	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant cond examiner?  1   Yes 2   No    25. Was case referred to mediaximiner?  1   Yes 2   No    27. Manner of Peath  1   Enatural   5   Per    2   Accident   Investigation	1 DLive 4 Preg 9 Unkr  ditions contributing to 6 0 S CO CO  dical Hospital: 1 U 28a. Date (Mor estigation	birth 2 Fetal de nant at time of deal nown  death but not resulti	eath 3 Sectopic printh 5 Other (sp.	ause given in Part I.  26. Place of Death  Other: 4 \( \text{Nursing Ho} \)	24a. Was autop performing the Check only or me 5 H sid	Month  sbacco use contribute in the state of	Day Year  to the cause of death?  Probably 4 Unknow autopsy findings available completion of cause of
ertification; To Be Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant condesses as a referred to medie examiner? 1   Yes 2   No  27. Manner of Peath 1   Matural 5   Per of Peath 2   Accident 3   Suicide 6   Cou	ditions contributing to declared the spital:    Hospital: 1   28a. Date (More pastigation under the company of	birth 2 Fetal de nant at time of deal nown  death but not resulti  Unpatient 2 Er of Injury 12 Part, Day Year)	eath 3   Ectopic price   5   Other (sp.)  Ing in the underlying care  R/Outpatient 3   DO  8b. Time of Injury	26. Place of Deatl  A Other: 4 Nursing Ho  Bc. Injury at Work?  1 Yes 2 No	24a. Was a autop perfor 1 Yes n (Check only or me 5 n sid 28d. Describe h	Month  ibacco use contribute in the state of	Day Year  to the cause of death?  Probably 4 Unknow  autopsy findings availab completion of cause of  s 2 No  ecify)
ertification: To Be Completed by Physician/Mec	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant condesserved to media examiner?  1   Yes 2   No    25. Was case referred to media examiner?  1   Yes 2   No    27. Manner of Death  1   Matural   5   Per   20   Accident   investigation   Accident   3   Suicide   6   Cool   4   Homicide   Continued    29a. Certifier   1   Certifier	ditions contributing to do  ditions contributing to do  dical Hospital: 1 U  anding estigation uld not be emined 28e. Place build  fying Physician: To the cal Examiner: On the build	birth 2 Fetal de nant at time of deal nown  death but not resulting the set of Injury and Year)  e of Injury - At homeling, etc. (Specify)  e best of my knowle	ath 3   Ectopic pn th 5   Other (sp)	26. Place of Deatl  A Other: 4 Nursing Ho  Bc. Injury at Work?  1 Yes 2 No	24a. Was a autop perfor 1 Yes n (Check only or me 5 sid 28d. Describe h 28f. Location (S City or Tow	Month  bacco use contribute to the set of th	Day Year  to the cause of death?  Probably 4 Unknow autopsy findings available completion of cause of as 2 No  Rural Route Number,  as stated.
in by the integral unested, page & should be detailed to use as strift cation; To Be Completed by Physician/Mec	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant condesserved to median examiner?  1   Yes 2   No    25. Was case referred to medianimer?  1   Yes 2   No    27. Manner of Peath  1   Matural   5   Per    2   Accident   3   Suicide   6   Cot    4   Homicide   Check only   2   Median    29a. Certifier   1   Certification   2   Median    29a. Certifier   1   Certification   2   Median	ditions contributing to description  ditions contributing to description  dical Hospital: 1 Use and the description of the desc	January Pearl of Injury - At hom ling, etc. (Specify)  a best of my knowling assis of examination	adh 3 Sectopic price of the sector of the se	26. Place of Death  Continue 26. Place of Death  Other: 4 \( \text{Nursing Ho} \)  3c. Injury at Work?  1 \( \text{Yes} \) 2 \( \text{No} \)  office	24a. Was a autop performent of the control of the c	Month  bacco use contribute to the set of th	Day Year  to the cause of death?  Probably 4 Unknow autopsy findings available completion of cause of secify)  Rural Route Number, as stated.
led in by the Tuneral director, page 2 should be detached for use as the Certification; To Be Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant condesserved to median examiner?  1   Yes 2   No    25. Was case referred to median examiner?  1   Yes 2   No    27. Manner of Peath  1   Matural   5   Per    2   Accident   3   Suicide   6   Cot    4   Homicide   Check only   2   Mediane)	ditions contributing to describe the distance of the distance	Inpatient 2 Fetal de la cown  death but not resulti  and injury an	asth 3   Ectopic price   5   Other (sp.   10   Other (sp.   11   Other (sp.   12   Other (sp.   13   Other (sp.   14   Other (sp.   15   Other (sp.   16   Other (sp.   16   Other (sp.   17   Other (sp.   18   Other (sp.   18   Other (sp.   19   Other (sp.   10   O	26. Place of Death  Other: 4 Nursing Ho  Bc. Injury at Work? 1 Yes 2 No  office  at the time, date and place, in my opinion, death occurrence.	24a. Was a autop performent of the control of the c	Month  bacco use contribute in the state of	Day Year  to the cause of death?  Probably 4 Unknow autopsy findings available completion of cause of secify)  Rural Route Number, as stated.

			For	State of M	larylan	•	artment of H		ind Mer	ntal Hyg	jiene	.cg.b.c	•	
			1 - State Registrar			Ce	rtificate of	Death			eg. No	000	14525	<del>-</del>
	Physici /Medic		1. Decedent's Name (First, Midd	lle, Last)			RAMD	ASS	Λ	Date of Dea Month	Day	200	3. Time of Death	,
	Examir		4a. Facility Name (If not institution	on, give street and number,	) -	1 1	4b City, Town, o	r Location of	f Death	1.	4c. (	county of De		
			The Johns No	NO SUNJAN	301	TRI		DRE	1	Ty			NE	
	Funeral Director		5. Social Security Number NONE	6. Sex 7. A	ge ( <i>In yr</i> s.	last birthday) Yrs.	Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day	Year)		Birthplace (State or Foreign Country) INIDAD, WI	į
			Usual Residence of Decedent		43		l			JI. ZZ	, 17	OI IK	INIDAD, WI	_
	irylan show	_	10a. State 10b. Count	у	10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits	
	Ba-f s	cto	MD. CARRO	LL		M.	r. AIRY	<u>.</u>					1 X Yes 2 □ No	
	with ti	Funeral Director	10e. Street and Number	TO DD			10f. Zîp Code			1		en of What	,	
	leath ns 23 must	erai	6619 BUFFA	LO RD.	Ever in U	.S. 13.	217 Was Decedent of H		in? (Specify	Yes or No-			DAD, WI merican Indian,	
ယ	or items		1 ☐ Never Married 2 ☐ Ma	rried Armed Forces'		1	Was Decedent of H		, Puèrto Rici	an, etc.)	i	Black, W.	hite, etc.	
21215-0036	72 hours after death with the Maryland natural', or items 23e or 28a-f show dical Examiner must be redified at	d by	3 Widowed 4 Divorce				1 ☐ Yes 2 📉 No	Specify:				Specify:	BLACK	
5-	72 h "natu	Completed		nt's Education est grade completed)		(Give	dent's Usual Occup kind of work done	during most	of working		16b. Kin	d of Busines	ss/Industry	
121	within ene. than "	dmo	Elementary/Secondary (0-12)	College (1-4or	5+)	ille.	DO NOT use retire	,				пом	7	
	should be filed within 72 hours after death with the Marylar of Mental Hygiene marked othar than "natural", or flems 23e or 28a-1 show merked othar than "natural", or flems 23e or 28a-1 show mere event, the Medical Examinar must be redified at	0	17. Father's Name (First, Middle			I	HOPEPIAKE		r's Name (F	irst, Middle,	Maiden S	HOMI Surname)	3	_
<u>la</u> n	ould be Mental arked o	To B	ROBER	T SANKA	R				HILDA	MAC	ELLL	AN W	ALL	
Maryland	s 1 and 2 should Health and Men Itam 27 is marke other traumetic	,	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailin	ng Address (Street	and Number	r or Rural R	oute Number	r, City or	Town, State	, Zip Code)	
	1 and Health am 27 other tr			ASS/HUSBAND	look 5		BUFFALO	RD., 1						_
Baltimore,	Pages 1 av		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 Removal from State	1 ~	emetery, crei	sition (Name of matory or other place	сө)	Date		20c. Loc	ation - City	or Town, State	
Ħ	_ <b>575</b>	1	' 4 ☐ Donation 5 ☐ Other (: 21. Signature of Funeral Service	Specify)	CI		5 CREMATO 2. Name and Addre		-14-20	05	RIV	ERDALI	E, MD.	_
Ba	Depar Impor any ir		DAM W	haralle St.	M0009	CI	HAMBERS F	UNERAI	L HOME	& CRI	EMAT(	ORIUM,	P.A. 20737	
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	st only one cause on each I	ine.	h. Do not ent	er the mode of dyir	ng, such as o					Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	a. CARD	IAC	TAM	PONADE						Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	s a conseq	uence or):			1				2 45055	
ы		in or	Sequentially list conditions, if any, leading to immediate	b. MSTA Due to (or as			REAST	CAN	CEK				2 YEARS	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>\</b>										
oʻ	be executed sician and burial-transit		resulting in death) Last	Due to (or as	s a conseq	uence of);								_
8760	be ye	Icai		d										_
9	ertifica ling ph	Physician/Med	IF FEMALE:	00- 14	1									_
Вох	eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Feta	Ideath 3□	Ectopic pregnancy Other (specify)	у			23	ld. Date of o Month	delivery Day Year	
P.O.	at the de by the a	ıysic	1 □ Yes 2.█ No 9 □ Unknown	9 Unknown	it ante or a	eath JL								
	res that igned b be deta	by Pr	Part II. Other significant condit	ions contributing to death I	but not res	ulting in the u	nderlying cause giv	en in Part I.		23e. Did tol	bacco us	e contribute	to the cause of death?	
rds	w require been sig should b									1 🗆 Ye	es 2 🔀	No 3□	Probably 4 Unknown	
Vital Records,	e law requ has been ge 2 shouli	Completed								24a. Was a autops		24b. Were	autopsy findings available o completion of cause of	
Ä		Com								perforr	ned? 2 No	death' 1 ☐ Y	? _	
/ita	yslcien: Th is certificate director, pag	Be	25. Was case referred to medic examiner?							heck only on				
of	hys this al dii	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 🔀 Inpati		ER/Outpatier				5 🗌 Reside			pecify)	_
	ding h. After fune	tlon	1 X Natural 5 ☐ Pend	28a. Date of Inji ing (Month, Datigation	ay Year)	Injury	Wor	k? Yes 2□N		. Describe no	ow injury	occurred		
Division	or Attanding after death. Diractor: After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of In	jury - At ho	me, farm, str	eet, factory, office					Number or	Rural Route Number,	-
D	o it te	Certification:	4 Homicide deten	building, e	tc. (Specif	v)				City or Town	n, State)			
	To tha Hospital or within 24 hours afte To tha Funaral Direct completely filled in the completel	edical (	29a. Certifier 1 Certifyl (Check only one) 2 Medica	ing Physician: To the best I Examiner: On the basis of and manner si	of examina	wledge, death tion and/or in	n occurred at the tir vestigation, in my o	me, date and pinion, death	place, and h occurred a	due to the ca	ause(s) a ate and p	nd manner lace, and d	as stated. ue to the cause(s)	
	To the To the	Me	29b. Signature and title of estifi	er			29c. Licens					_	nth, Day, Year)	
	ري .		) DE	X u	EDICA	4L DOC	TOR RE	50	01	A	PRIL	9, :	2005	
	1		30. Name and address of person	n who completed cause of	death (Item	1 23a) (Type,	Print)							_
			GAUTAM BHAV					SUIT	€ 901	1 BA	LTIM	ORE,	HD 21287	_
:	Sta Registi		31. Date filed (Month, Day, Year APR 13	2005 Regist	rars Signa	ture App	NO.							

		For State Registrar	State	of Marylan		artment of H		nd M		Reg.	00	05	145	26
		1. Decedent's Name (First, Middle, L							2. Date of Month April		Day	Year	3. Time of	
Physicia /Medic		Edwin M.	Rzepka,	Sr.					April	11, 2			4:58 a	L. M
Examin		4a. Fecility Name (If not institution, g	ve street and nu	umber)		4b. City, Town, or	Location of	Death			4c. Coun	ty of Death		
		Arden Courts Silver				Silver Spr		14 11-2			bntga			
Funeral	y I		Sex 1⊠M 2□F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.		Day, Ye		Cour		-
Director		234-38-2012		77	115.				Sep.	29,1	927	West	Virgi	nia
and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	10d. inside Ci	ity Limits
Aaryli r sho	5				0.1								1 🗌 Yes	2 <u>₩</u> No
28a-	Director	Maryland   Montgon 10e. Street and Number	ery		SIIVe	er Spring 10f. Zip Code				10g.	Citizen o	f What Coul	ntry?	
hours after death with the Maryland tural', or Itema 23a or 28a-f show al Examirer must be recilified at	<u>a</u>	2202 Dankan Aman					20902				IISA			
na 23	Funerai	2203 Dexter Aver	12. Was De	cedent Ever in U	.S. 13.	Was Decedent of H		gin? (Spe	ecify Yes or	No-	14. Ra	ace - Americ		
r Her	F	1 Never Married 2 Married		2 🗌 No		rres, specify Cuba 1 □ Yes 2132 No		, Fuello	nicari, etc.)	,		lack, White,	etc.	
al', o	þ	3 XWidowed 4 ☐ Divorced	If Yes, G Year or	ive Dates: WW		TES ZIXINO	эреспу.			- Si-5/11	Spec		hite	
72 ho	Completed	15. Decedent's (Specify only highest of	Education	<i>t</i> )	(Give	dent's Usual Occup	during most	of worki	ing	16b	. Kind of	Business/In	dustry	
within 7 jiene. r than "n	Pp.	Elementary/Secondary (0-12)		(1-4or 5+)		DO NOT use retired								
be filed within 72 ital Hygiene. id other than "naleevant, Ire M. Lich	ő		4		Mechai	nical Eng			/Final 14:				of Nav	У
be filed tal Hyg d othe evant,	Be	17. Father's Name (First, Middle, La	st)				18. Mothe	rs Name	e (First, Mio	odie, Mai	aen Sumi	ame)		
permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic evant, It a Ingone.	ဥ		pka	-	F 5		Eva	_	ombek			- Ctata Ti	Codel	-
2 sho and is m		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street	and Numbe	r or Rura	al Route Nu	ımbər, C	ity or Iow	m, State, Zij	o Code)	
and ealth m 27		Edwin M. Rzepka,	Jr.	Son		Dexter A	venue		lver	Spri	ng M	arylain - City or To	nd 209	02
of H of H if Ita		20a. Method of Disposition 1∑ Burial 2 ☐ Cremation 3	☐Removal from	n State Ca	cemetery, crei	matory or other plac Heaven	ce)	,	Jato	200	. LUCATIO	in City of th	OWII, OLALE	
Pag ment ant: ury c		' 4 ☐ Donation 5 ☐ Other (Spe	cify)	Ga		Cemeter	y A		5,200	5 51	lver	Spri	ng,MD	
permit. Depart Import any Inj		21. Signature of Funeral Service Lic	ensee 1 4 4	LN/	F	2. Name and Addre	Coll	ins	Funer	al H	lome,	Inc.		
807788		Jan Collin	y VCO	041	50	00 Univer	sity	B1vd	.,W.,	Silv	er S	pring		
		23a. Part Lenter the disease, or co shock, or heart failure. List or	mplications that ly one cause on	t caused the dea each line.	th. Do not en	ter the mode of dyir	ng, such as	cardiac	or respirato	ry arrest,			Approximate Interval Bet Onset and	tween
Physician		Immediate Cause (Final disease or condition	a 7\c	tvanced De	montia							111		
/Medical		resulting in death)	Due to	o (or as a consec	quence of):									
Examiner		Sequentially list conditions.	h	pertensio										
p #	nei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		o (or as a conse										
ate be executed hysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	C	iabetes Me o (or as a consec										
e be ex sicien a burial	E	,,		steoarthri										
	dicai		d	sceoar an i	CIS									
uires that the death certific signed by the attending p d be detached for use as	Physician/Med	IF FEMALE:	23c If yes c	outcome of pregn	ancv						234 [	Date of deliv	/en/	
ath c	lan	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fet	al death 3	☐Ectopic pregnanc	у					Month	,	Year
the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unk		death of	Other (speedif)								
hat the sed by detac		Part II. Other significant condition	s contributing to	death but not re	sulting in the u	ınderlying cause gr	ven in Part I.		23e. 0	Did tobac	co use co	ontribute to	the cause of	death?
signed b	d by								1	1 🗌 Yes	2 🗆 No	3 ☐ Pro	bably 4 🙀	Unknown
w requires been sign should be	ompleted								242 \		24	h Were aut	opsy findings	available
has t	ldu				-				a	autopsy performe	d?	prior to co death?	ompletion of a	cause of
: Th	S								1 □ Y	es 2X	No	1 🗆 Yes	2□ No	
ding Physician: The lav h. After this certificate has funeral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		<b></b>	Ott			th (Check o	100	×	Other (Speci	Assi	sted
Phys r this ral dir	5	1 ☐ Yes 2 🛣 No 27. Manner of Death	11	☐Inpatient 2☐ te of Injury	ER/Outpatie	IN SELDON	4 🗆 140	irsing Ho	ome 5 1 F	_			Liv.	ing
Jing After funer	ion	1 X atural 5 Pending	(Mo	onth, Day Year)	Injury	Wo	nk? ]Yes 2⊟	No						
Attending or death. rector: After by the func	cal	3 Suicide 6 Could no	t be 200 Pla	ce of Injury - At I	home, farm, st	reet, factory, office			28f. Locati	ion_(Stree	et and Nu	mber or Rui	ral Route Nur	mber,
after Direct in by	ertification;	4  Homicide determin	bui	ilding, etc. (Spec	ify)				City o	r Town, S	state)			
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	O	29a. Certifier 1 XCertifying	Physician: To t	the best of mv kr	nowledge, dea	th occurred at the ti	ime, date an	nd place,	and due to	the caus	se(s) and	manner as	stated.	
24 hr 24 hr Fun stely	edicai	(Check only 2 Medical E	caminer: On the	basis of examir anner stated.	nation and/or in	nvestigation, in my	opinion, dea	th occur	rred at the ti	ime, date	and plac	e, and due	to the cause(	(s)
To the within To the comple	Mec	29b. Signature and title of certifier	. 7/	0	121	29c. Licen	se number			29d	. Date sig	ned (Month	, Day, Year)	
7 1 5 1 € 1		1 Cect	V	otro	1-1:0		20279			Arc	ril 1	1, 2005	5	
124		30. Name and address of person w	ho completed ca	ause of death (Its	am 23a) (Tvna				13.5					
		Kirti Vohra, M.					yland 2	0817						
C+	ate	31. Date filed (Month, Day, Year)	34	Registrar's Sign	nature /	aske)								
ol Regista		ADD 13	2005	denne l	J. AD	The state of the s								

		4	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2000
			negistral
	Physicia	pit.	1. Decedent's Name (First, Middle, Last)  KLEORA LODEMA SCHILDTKNECHT  2. Date of Death Month Day Year O44(QM
	/Medić		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	Examin	21	Washington County Hospital Hagerstown Washington
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months) Days Hours Min. (Month, Day, Year) 1001
	Director	-	217-74-6280 THE PERIOR OF Decedent
	land ow		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Mary -f sh	ţō	Maryland Washington Hagerstown 1X Yes 2□No
	th the	lrec	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	23e ust b	ral	1304 Pennsylvania Avenue 21742 U.S.A.  11 Marital Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
36	within 72 hours after death with the Maryland ene. Than "natural", or Items 23e or 28e-f show the Madical Exametra count to notitied at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1
21215-0036	hin 72 hours a a. a. an atural; o Medical Exam	ted	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working
215	thin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Iife. DO NOT use retired)
N	T		5 IN / A
anc	be do be	Be c	Allen Charles Schildtknecht Violet Savannah South
Maryland	d 2 should be had and Mental 7 is marked of treumatic every	은	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	nd 2 ulth a 27 is r tre		Charles A. Schildtknecht Brother 17608 Woodlawn Drive, Hagerstown, Md. 21740
ore,	S - = 0		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State  20c. Hogger Place of Date control of the place)
Ë	Pag nent ant: I		'4 Donation 5 Other (Specify) Rose Hill Cemetery   U4-19-U5 Hagerstown, Maryland
Baltimore,	permit. Page Department o Importent: If any injury or once.		21. Signature of Funeral Service Licensee Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740
	Pnysician		23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in a chaline.  Immediate Cause (Final disease or condition)  Approximate Interval Between Original Approximate Interval Between Original Approximate Interval Between Original Approximate Interval Between Original Approximate Interval Inter
	/Medical Examiner		Due B (of as a consequence of the consequence of th
	Lxammer	آ ا	Sequentially list conditions, if any, leading to immediate  b. Due g of as a consequence of):
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due in for as a consequence of):  Out of the sequence of th
o,	ate be executed thysician and the buriat-transit	Еха	resulting in death) Last Due to (or as a consequence of):
8760	ate be ex hysician the buria	dlcal	d
Box 6	death certific e attending p id for use as	Physiclan/Med	IF FEMALE:  23c. If yes, outcome of pregnancy 1
P.0	± ≥ ∞	Phys	9 Unknown  Part II. Other ignificant conditions contributing to the cause of death?  23e. Did tobacco use contribute to the cause of death?
ds,	w requires that been signed to should be det	Completed by	(Pulsus Pulsy Justo interflus polation 1 yes 200 3 Probably 4 Unknown
Sor		lete	24a. Was an 24b. Were autopsy findings available
Re	e ta has	шc	autopsy prior to completion of cause of performed? performed? death?  1 □ Yes 2 ☑ No
tal	icien: Th certificate rector, pag	a	25. Was case referred to medical 26. Place of Death (Check only one)
Į Š	ding Physicien: n. After this certific	To B	examiner? 1   Yes 2   1   1   2   ER/Outpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)
O U	ffei ffei		27. Manner of Death 1 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Work?
Sio	Attending ir death. ector: After by the fune	icati	1 Gratural S Perfuting 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
Division of Vital Records,	after d Direc	Certification:	4 Homicide determined building, etc. (Specify)
_	To the Hospitel or Attendis within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Co	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	o the	Med	20d Date signed (Month Day Year)
	- 5 - 0		Stroet (MAN, MD) 136655 Houl 16 2005
	. (		29b. Signature and title of certifier  The Chan MD  30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)  324 Ears Antighthm STNUT - Wile 700. Hagus How MD 21140
	H-7		31. Date filed (Month, Qay, Year) 32. Bregistrar's Signatuse
:	St Regist	ate trar	APR 18 2005 Apres 15. Aprell

			1 - For State Registrar	State of Ma	•	artment of I		nd Mental Hy	giene Reg. No./) ()	3% 1n+			
			Decedent's Name (First, Middle, Last,	)				2. Date of De	ath 4	45	3. Time of Death		
	Physicia /Medic		Rachel B	. Smith				April 8	Day 3, 2005	Year	8:57 a M		
	Examin		4a. Facility Name (If not institution, give 3722 Manor Road	street and number)		4b. City, Town, Chevy (	or Location of E Chase		4c. County	4c. County of Death Montgomery  9. Birthplace (State County)			
I	Funeral Director		5. Social Security Number 6. Security Number 1579 • 58 • 7297	x 7. Age □ M <b>20X</b> F	(In yrs. last birthday, 93 Yrs.	If Under 1 Year Months Days		Min. 8. Date of Bir (Month, Date of Ct. 2.	iv. Year)				
	ס		Usual Residence of Decedent					0000	,, ->				
	arylar show	_	10a. State 10b. County		10c. City, Town or L					1	10d. Inside City Limits		
	the M	ecto	MD Montge	omery	Che	vy Chase			10- 01	14% - 1 0	1 Yes 2 No		
	with la or	늅	3722 Manor Road	Apt. 4		,	0815		10g. Citizen of	S.A.	itry ?		
	death ms 23	era	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	. 1		n? (Specify Yes or No Puerto Rican, etc.)		ce - Americ	an Indian,		
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Items 23s or 28s-f show raumatic event, the Medical Evanthar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🛣 No 1f Yes, Give Year or Dates:	0	If Yes, specify Cub 1 ☐ Yes 2 🗓 No		Puerto Rican, etc.)	Bla Specif	ck, White, y: Wh	etc. nite		
<u>0</u>	72 ho	Completed	15. Decedent's Edu (Specify onfy highest grad		16a. Dece	dent's Usual Occu kind of work done	pation	f working	16b. Kind of B	usiness/In	dustry		
21	ithin nan "	nple	Elementary/Secondary (0-12)	College (1-4or 5-	+) /ife.	DO NOT use retire	nd)	HOIKING					
7	iled w Hygier ther ti		17. Father's Name (First, Middle, Last)	5+	Lan	guage Tea		s Name (First, Middle			c Schools		
and	d be f antal h ced of	o Be	Eugene B	lack				amie Coler		10)			
Ž	should nd Me mark	은	19a. Informant's Name/Relationship (T)		19b. Mail	ng Address (Street		or Rural Route Numb		State, Zic	(Code)		
S	nd 2 aith a 27 is or trau		Sandy Weis/ Niece	2				e Sarasot			,		
Baltimore, Maryland 21215-0036	permit. Pages I and 2 should be Deperment of Health and Menta Important: If Item 27 Is marked any injury 920ther traumatic events.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Disp cemetery cre Cedar Hi	osition (Name of Matory or other pla II Cemete	ce) Y	/12/05	20c. Location - Suitlan				
Balti	permit. Depertra Importa any inju		21. Signature of Firm al Service Licens	Bro				Joseph Gav venue N.W.		ons,	Inc.		
	Pnysician /Medical	i I	23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a										
	Examiner			Due to (or as a	consequence of):								
		er	Sequentially list conditions, if any leading to immediate	Due to (or as a	consequence of):								
	ficate be executed physician and is the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
o,	an an rial-tr	Exa	resulting in death) Last	Due to (or as a	consequence of):	_							
8760,	ate be nysici he bu	dical		d									
9	n certifica anding ph use as t	Med	IF FEMALE:										
.O. Box	ne deatl the atte	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 ☐ Fetal death 3 [	⊒Ectopic pregnanc ☐ Other (specify) _	у			te of delive onth	ery Day Year		
٥.	that the	by Ph	Part II. Other significant conditions co.	ntributing to death bu	t not resulting in the t	inderlying cause gr	ven in Part I.	23e. Did 1	obacco use cont	tribute to th	ne cause of death?		
Records,	w requires that been signed b should be deta	d be						10	Yes 2 TNo	3 🗆 Prob	ably 4 Unknown		
000	aw re s bee 2 sho	Completed						24a. Was	an 24b.	Were auto	psy findings available mpletion of cause of		
	The law ate has b page 2 st	mo						— auto perfo 1 ☐ Yes	rmed? _	prior to cor death? 1 □ Yes			
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?				26. Place of	Death (Check only					
of V	Physicien: this certific ral director,	은	1 ☐ Yes 2 ☑ No	Hospital: 1 🗌 Inpatier		II 3 DOA		ing Home 5 🛣 Resi			v)		
п	ling P	inol:	27. Manner of Death  Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time (	Wo	rk?		how injury occur	red			
isic	Attending r death. sctor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	28a Place of Inju	ry - At home, farm, st		]Yes 2□No		Street and Numb	or or Pura	I Pouto Number		
Division	after Direct	Certification;	4 Homicide determined	building, etc.	(Specify)	reet, ractory, ornce		City or To	wn, State)	or or Hura	i noute ivalitoer,		
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)  1X Certifying Phy 2 Medical Exami	sician: To the best of iner: On the basis of and manner stat	examination and/or in	h occurred at the ti	me, date and popinion, death	place, and due to the occurred at the time,	cause(s) and madate and place,	anner as st and due to	ated. the cause(s)		
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	1 1		29c. Licen	se number		29d. Date signe	d (Month,	Day, Year)		
			1 Justanh	17 Bm	1	22	2774		4.11	:05	_		
	20		30. Name and address of person who ca	ompleted cause of de	ath (Item 23a) (Type	Print)							
			Frederick Smith,				1300 C	hevy Chase	e, MD 2	0815			
	Sta Registr		31. Date filed (Month, Day, Year)  APR 13 200	3 Registra	r's Signature	will							

Pnysician /Medical Examiner and I-transit The law requires that the death certificate be executed attending physician a for use as the burial-Box 68760, P.O. Division of Vital Records.

or Attending Physicien:

Hospitel

To the l

within 72 hours after

Hygiene.

Baltimore, Maryland 21215-0036

funeral director, page 2 within 24 hours after death.

To the Funerel Director: A completely filled in by the fu

Be Completed Certification: To

25. Was case referred to medical 27. Mannecof Death 29a. Certifier

29b. Signature and title of certific O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

examiner?

1 Natural

2 Accident

3 Suicide 4 Homicide

(Check only one)

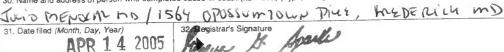
1 Yes 2 No

31. Date filed (Month, Day, Year) **APR 14** 2005

5 Pending

investigation

6 Could not be



Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

v D

Coarle

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Eleminer: The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D-31912

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21702

29d. Date signed (Month, Day, Year)

105

Registrar

State Registrar

31. Date filed (Month, Day, Year)

lasha Z Green bera

Jos fall Greense

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Begistrar's Signature

ORIGINAL

OCME

111 Penn Street

April 18 2005

Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** tock man /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5. Social Security Number of MARY LAND MEDICAL SYSTEM BALMMORE None 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Dec. 12, 19 Birthplace (State or Foreign Country) **Funeral** Days Min 1 □ M 2 🔀 F **Director** 217-17-9334 29 1975 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite M. of the Maryland Extenditor matal be modified at any injury or other traumatic event, Ite M. of the Maryland at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1⊠Yes 2□No Be Completed by Funeral Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Coats Ridge Place United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Cleaner Comercial Cleaning 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kenneth R. Smith ည Joyce Ann Deal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry E. Stockman / Husband 9 Coats Ridge Place Frederick, Maryland 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State April 16, 2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signalure of Juneral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Heart 2440015 disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Mediastina Sequentially list conditions, if any, leading to immediate Completed by Physician/Medical Examiner Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and nding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 👿 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending after death.

| Director: Aft d in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 15 801 30. Name a d address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene St BATIMURE, istrar's Signature 11a 5 2005 Registrar

_			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of F		Mental Hy	giene Reg. No.	2005		32			
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Ruth Naomi	Stinson	n			2. Date of De Month April		005 Year	3. Time of Death				
	Examin		4a. Facility Name (If not institution, give s 1321 Flag Harbor E	Blvd.		4b. City, Town, o	nard		4c. County of Death Calvert						
	Funeral Director		5. Social Security Number 6. Sex 226-30-4302	IN 00 F	e (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		926	9. Birthp Cour West	lace (State or Fore try) Virginia	eign <b>3</b>			
920	Maryland	tor	10a. State 10b. County Maryland Calvert		10c. City, Town or Lo St. Leona					1	0d. Inside City Lim				
	h with the 23e or 28e	al Director	1321 Flag Habor Bl	.vd.		10f. Zip Code 20685			10g. Çitiz Unit	en of What Cour ed State	ntry?				
	d within 72 hours after death with the Maryland Jene. r than "netural", or Items 23e or 28e-f show It e Macical Examiner must be natified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 XN If Yes, Give Year or Dates:	No I	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🔀 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	i	4. Race - Americ Black, White, SpecifyWhite	etc.				
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altimore, Maryland	nd 2 sh aith and 27 is m r traum		19a. Informant's Name/Relationship (Ty) Nancy Lynn Chevert		19b. Mailin hter 8424 F	g Address (Street Halsey Rd	and Number or . LUSby	Rural Route Numb , MD 2065	er, City or 57	Town, State, Zip	Code)				
	Page nent o ant: If ury or		20a. Method of Disposition  1  ☐ Burial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Dispo cemetery, crem Meadowric	natory or other place lge Memor			Elkri	ation - City or To					
Ball	permit. Departinports any inj		21. Signature of Funeral Service License		440	)5 Broome	s Islan	ausch Fur d Rd. Por	rt Re	Home public N					
	Anysician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approxim Interval B Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):												
8760,	death certificate be executed as eath certificate be extending physician and ad for use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence of):	U									
.O. Box 68	the death certify the attending iched for use a:	Physician/Medical	hysician/Med	hysician/Med	nysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	,		23	3d. Date of delive Month	ry Day Year	
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	To the Hospital within 24 hours a To the Funaral t completely filled	Medic	one)  29b. Signature and title of certifier	and manner sta	nted.	29c. License	e number		29d. Date	signed (Month, I	Day, Year)				
•	5		30. Name and address of person who co	~			Proma	e Fode	-	m) à	0678				
	Sta Registr		31 Date filed (Month Day Vess)	22 Popietro	Signature										

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

For State Registrar

**ORIGINAL** 

29c. License number

	•	- For State of Waityland / Department of Fleath and Weritar - State Registrar Certificate of Death	Reg. I								
Physicia	n	1. Decedent's Name (First, Middle, Last)  FRANK F. THURSTON, JR.		Day Year	3. Time of Death						
/Medica Examine		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Upper Chesapeake Medical Center  4b. City, Town, or Location of Death  Bel Air		4c. County of Death	unty of Death Harford						
Funeral Director			of Birth th, Day, Yea ./1924	ar) 9. Birth Cou Penns	place (State or Foreig intry) Sylvania						
aryland show	_	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   MD   Harford   Py1esville			10d. Inside City Limi						
with the M a or 28a-f Le notifie	Funeral Director	10e. Street and Number 1040 S. Constitution Road 21132	10g.	Citizen of What Cou	·						
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Eventi at most be notified at once.	by Funera	11. Marital Status  1 Never Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married  3 Widowed 4 Divorced  12. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et If Yes, Specify:  13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et If Yes, Specify:	or No- c.)	14. Race - Amer Black, White Specify: Wh							
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and 2 Balth a n 27 ii		Jean W. Thurston/Wife 1040 S. Constitution Road,	_								
Pages 1 ment of Ho tant: If iter jury or oth		20a. Method of Disposition  1  Burial 2 X Cremation 3 Removal from State  4  Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Evans Eagle Cremat. 4/22/2005		Location - City or 1	own, State						
permit Depart Import any in		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Harkins Funeral Home, Inc., 600 Main St., Delta, PA									
Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. BILATERAL PNEUMONIA	tory arrest,		Approximate Interval Between Onset and Death						
Medical Examiner and Buysician and I say the burial-transit	Medical Examiner	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	VŒ	R.	4 YEAR						
	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[ Yes 2 \] No 9 \[ Unknown \] 23c. If yes, outcome of pregnancy 1 \[ Live birth 2 \] Fetal death 4 \[ Pregnant at time of death 9 \] Unknown 5 \[ Other (specify) \]		23d. Date of delin	very Day Year						
equires that I sen signed by lould be deta	d by Phy	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the cause of death?						
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s aft	0	29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due  (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the									
ne Hospital on 24 hours aft ne Funeral Di	edical C	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.									
To the Hospital or within 24 hours aft To the Funeral Discompletely filled	Medical C	one) and manner stated.  29b. Signature and title of certifier 29c. License number		Date signed (Month							
To the Hospital or Attenda within 24 hours after death To the Funeral Director: A completely filled by the fu	Medical C	one) and manner stated.  29b. Signature and title of certifier 29c. License number	0	4-21	-						

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			State of Maryland / Department of Health and 1- State Unpend Item 23a&27 per me G843 5-1,7-05 tas Certificate of Death  1. Decedent's Name (First, Middle, Last)									2. Date of Death 3			
	Physici: /Medic		Joann Dawn Tes	terman							April	23	2005		
	Examin		4a. Facility Name (If not institution,		nber)				Location of	Death		4c. Cour	nty of Deat	h	
			2817 B Biggs Hig					orth		à 11-a - T			cil		
55	Funeral Director		5. Social Security Number  219-70-3840  Usual Residence of Decedent	Sex 1 □ M 2 <b>X</b> □ F	7. Age (In )	yrs. last birthda 38 Yrs.	Month	der 1 Year s Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da May 21	th y, Year) , 1966	Co	hplace (State or Foreign untry) TYLand	
- ,	laryland show		10a. State 10b. County		10c.	. City, Town or	Location							10d. Inside City Limits	
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	or 289-f	Director	10e. Street and Number					Zip Code				10g. Citizen	of What Co	untry?	
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	after death w or itema 23a mirer must t	Funeral	11. Marital Status	12. Was Dece	rces?	in U.S. 13	3. Was Dec If Yes, sp	edent of H secify Cuba	ispanic Orig ir., Mexican,	in? (Spe Puerto l	ecify Yes or No Rican, etc.)	)- 14. R	ace - Ame lack, White	rican Indian, e, etc.	
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9	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28e-f show fre Medical Exercites frost be notified at	ted	15. Decedent's			16a. De	edent's Us	sual Occup	ation	-44:1		16b. Kind of	Business/I	Industry	
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Maryland 21215-0036	12 should be filed within and Mental Hygiene. 7 is marked other than "reumatic event, I'le Me.	Be	17. Father's Name (First, Middle, La	st)							(First, Middle	, Maiden Sum	ame)		
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Division of Vital Records, P.O. Box	Attending Physician: The law requires that the death certific reach.  death.  ector: After this certificete has been signed by the attending got the funeral director, page 2 should be detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown		irth 2 F ant at time	Fetal death	B⊟Ectopic B⊟ Other (						Date of deli-	very Day Year	
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	v ithi To t	Σ	29b. Signature and title of certifier				2	9c. License				29d. Date sign			
			> unes2	*				OCM	巴			April	24, 2	2005	
_			30. Name and address of person wh		e of death (	(Item 23a) (Typ	e, Print)	111	Penn	Str	eet Ba	ltimor	e, Ma	ryland 2120	
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 5 2005	L.	egistrar's Si	ignature									

Amend Item: 5, per F.H G-851 1/6/06 reb
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** එපී, 200ීප් Homer Leroy Vance April 11:20am /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Beverly Health Care Washington Hagerstown, | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Mar. | Tay, Year | 21 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 219-14-7<del>5</del> 1XM 2□F 84 Yrs. Director Usual Residence of Deceden with the Maryland 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits r than "netural", or items 23a or 28a-f shov Tre Madical Expedient trust be notified at MD Washington Clear Spring X□Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12421 Nesbitt Ave 21722 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Q / Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status NO Yes 2 No 1943 – 1946 Year or Dates: 1 ☐ Never Married 2 X Married Specify White 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Aircraft mfg. Elementary/Secondary (0-12) College (1-4or 5+) Metal Worker 12th grade nd 2 should be filed atth and Mental Hygic 27 Is marked other r treumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 is marked c any Injury or other treuments Kenneth C. Vance Retha N. Shives 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12421 Nesbitt Ave. Clear Spring, MD 21722 Leila Vance wife 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Y☐Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Clear Spring, MD St. Paul Cemetery 2005 21. Signature of Brief Service Con 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc lays. 11 P.O.Box 310 Clear Spring, MD 21722 Approximate Interval Between Onset and Death **Physician** 2 Moultis /Medical Due to (or as a consequence of Examiner val ular 2 MOUITE Cordiae Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lue to (or as a consequence oi). Examiner death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) detached φ s been signed be should be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has by page 2 s certificate 1 Yes 2 No director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) After the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Attending. 1 Natural 2 Accident Injury To the Hospitel or Accomming 24 hours after death.
To the Funerel Director: After the Funerel Director of the funerel in by the funerel in by the funerel in 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4-15-05 D28365

3H-10+1

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

DHMH 17 Rev 1/2001

State Registrar 368 nuel

Street Hagestown 190

30. Name and address of person who completed cau of death (Item 23a) (Type, Print)

APR 1 0 2005

SHAM

32. Registrar's Signature

Manzew

31. Date filed (Month, Day, Year)

			State of Maryland / D	-	rtment of He		ental Hy	giene,	2005	14537
	Physicis		Decedent's Name (First, Middle, Last)				2. Date of De	Day	2005 <sup>ear</sup>	3. Time of Death
	Physicia /Medic		Gregg Veresh				April	<u> </u>		9:25 Р. м
	Examin	er	4a. Facility Name (If not institution, give street and number) Suburban Hospital		4b. City, Town, or Lo				County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bin	rthday)	Bethesda	f Under 24 Hrs.	8. Date of Bir	rth	ontgomes 9. Birth	place (State or Foreign
	Director		312–52–8118 <sup>1</sup> 又 <sup>M 2□ F</sup> 55	Yrs.	Months Days	Hours Min.	(Month, Da January	17,19	50 Mic	higan
	pur		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town	vn or Loc	ation				1	10d. Inside City Limits
	daryla f sho	٥	Maryland Montgomery Rockvi							1X Yes 2 □ No
	r 28a-	Director	10e. Street and Number		10f. Zip Code			10g. Citiz	en of What Cou	ntry?
	h with		4807 Estter Drive		20852			Unit	ed Stat	ces
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	Vas Decedent of Hisp Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto	ecify Yes or No Rican, etc.)	o- 1	4. Race - Ameri Black, White,	
36	ours after death with the Maryla ral', or Items 23a or 28a-f shov Exercities must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☑ Divorced Year or Dates:	1	☐ Yes 2X No	Specify:			Specify: Whi	te
9	2 hou		15. Decedent's Education 16a.	ı. Deced	ent's Usual Occupation	on		16b. Kin	d of Business/In	dustry
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Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show raumstic event. It's Modeal Exeminer must be notified at	Be c	17. Father's Name (First, Middle, Last)  Alfred Veresh				Nauxel		ourname)	
Z Z	should nd Me mark matic	ဥ		b. Mailin	g Address (Street and				Town, State, Zij	Code)
Ž	alth a alth a 27 le		Rachel Milner/ Friend 48	307 I	Estter Dri	ve, Rock	wille,	MD 2	20852	
Baltimore,	es 1 go		20a. Method of Disposition  20b. Place of cemetage  1 Burial 2 Cremation 3 Removal from State	of Dispos	sition (Name of natory or other place) Universi	ty Apri	il 8		ation - City or To	
Ĭ.	. Pag tment tant: jury c		* 4 KDonation 5 Uther (Specify) Medica	1 0	enter	200	)5		nington,	
Bal	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany or other traumatic event, I'm Medical ponce.		21 Inature of 9 Ineral Service Licensee	22.	P.C	of FacilityColu	umbia M 3007 Wa	ortua shing	ry Serv	rices, Inc. C. 20037
	J		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ente	er the mode of dying,	such as cardiac o	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Pnysician / /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Metastatic No.		xigkins Ly	mphona_				
25pm	Examiner		Due to (or as a consequence	σι):						
2		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	of):						-
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9	certificate be executed ding physiclan and ise as the burial-transit		resulting in death) Last Due to (or as a consequence	or):						
09289	ficate physis the	edical	d							
8 8	n certi anding use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant  23c. If yes, outcome of pregnancy  1 □ Live birth  2 □ Fetal death	b 3	Ectopic pregnancy			2:	3d. Date of deliv	*
O.B.	e deat he att	sicia	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		Other (specify)			0	Month	Day Year
- 9.	hat th ed by 1 detach	Phy	Part II. Other significant conditions contributing to death but not resulting in	in the ur	iderlying cause given	in Part I.	23e. Did	tobacco us	e contribute to t	he cause of death?
4 8	uires t signe Id be	Completed by	Respiratory Failure Secondary to					Yes 25		pably 4 Dunknown
Cor	s beer	olete					24a. Wa:		24b. Were auto	ppsy findings available
C / E	The la	mo					auto perf 1 ☐ Yes	ormed?	death?	mpletion of cause of 2 No
Vital	ctor. p	BeC	25. Was case referred to medical examiner?			26. Place of Death	(Check only	one)		
200	Physician: this certific ral director.	၉	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	- '		4 Nursing Ho				(y)
<b>≫</b> uo	ding F h. After funera	tlon	1 Natural 5 Pending (Month, Day Year)	Time of Injury	28c. Injury a Work? M 1 ☐ Ye	s 2 No	28d. Describe	now injury	occurred	
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O É	al or A s after al Direc ed in by	Certi	4 ☐ Homicide determined building, etc. (Specify)				City or Te	own, State)		
16	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledgram on the basis of examination are and manner stated.							
0	To th withir To th comp	M	29b. Signature and title of beyffier		29c. License r				signed (Month,	
			• HIT		D00613			April	7, 200	
			30. Name and address & person who completed cause of death (Item 23a) Atul Rohatgi, M.D. 8600 Old Geo	orge	etown Road	, Bethes	sda, MD	207	84	
	Sta Registr		31. Date filed (Month, Day, Year)  APR 1 3 2005  33. Registrar's Signature	doe	de s					

			1 - State of Maryland / Dep	artment of Healtl rtificate of Dea		ental Hygiei Reg.		)5	14538
ı	Physicia /Medic		Decedent's Name (First, Middle, Last)     Mary Virginia WARNER			2. Date of Death Month April 15	Day 2005	Year	3. Time of Death 1:40 ам
	Examin		4a. Facility Name (If not institution, give street and number) Homewood Nursing Home	4b. City, Town, or Locati Williamsp	ort		4c. County o	ingto	
	Funeral Director		5. Social Security Number 6. Sex 1 M 200 F 7. Age (In yrs. last birthday, 97 Yrs.	Months Days Hou	urs Min.	8. Date of Birth (Month, Day, Ye Aug. 17,1	907	9. Birthpl Count Mary	ace (State or Foreign try) Land
	Maryland a-f show	tor	10a. State10b. County10c. City, Town or LMarylandWashingtonHagerst					10	0d. Inside City Limits  12
	with the	i Director	10e. Street and Number 130 East North Avenue	10f. Zip Code 21740		10g.	Citizen of W		try?
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "naturel", or Items 23a or 28a-f show aumatic event, the Medical Evanthal must be Indiffed at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 \ Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 \ No If Yes, Give Year or Dates:	Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2 ☑ No Spec		cify Yes or No- Rican, etc.)		- Amenca k, White, k	
Maryland 21215-0036	vithin 72 hou ne. hen "nature e Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1-4or 5+)	most of workin	ng 16b	. Kind of Bus			
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rylar	should benta	To	Nathaniel E. Shaw  19a. Informant's Name/Relationship (Type, Print)  19b. Mail	ing Address (Street and Nu		ettie Aus			
	1 and Health tem 27 other tr		D. Elaine Hollingsworth - daughter 3  20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition cemetery, cre	4860 Harry B existion (Name of ematory or other place)	Byrd Hi	ghway, Ro	•	ill,	Va. 20141
Baltimore,	permit. Pages Department of Important: If i eny injury or o		21. Signature of Eurorat Service Licensee	ven Cemetery 22.Name and Address of Fa 15 East Wils	19 <b>,</b>	2005 Ha Minnich F	uneral	1 Hon	
8760,	Physician and /Medical Examiner supplies the private in the privat	dicai Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	nter the mode of dying, such	h as cardiac o	respiratory arrest,			Approximate Interval Between Onset and Death
O. Box 6	ne death certif the attending thed for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)			23d. Date Mon	e of delive	ry Day Year
rds, P.	w requires that the bear signed by should be detact	b	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in P	Part I.	23e. Did tobacc		ibute to th	e cause of death?
Vital Records,	The ate h page	Completed				24a. Was an autopsy performed	12 p	Vere autoprior to con eath?	osy findings available apletion of cause of 2 No
	Physician; The this certificate har ral director, page	To Be	25. Was case referred to medical examiner?  1  Yes No		0.0	(Check only one) ne 5 ☐ Residence	e 6 □Othe	or (Specify	·)
Division of	ling After fune	Certification;	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined.  28a. Date of Injury (Month, Day Year)  28b. Time (Month, Day Year)  28b. Time (Month, Day Year)  28b. Place of Injury - At home, farm, s	of 28c. Injury at Work?  M 1 TYes 2	2 🗆 No	28d. Describe how in 28f. Location (Street	njury occurre	ed	
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier  (Check only one)  Descripting Physician: To the bast of my knowledge, dea (Check only one)  Medical Examiner: On the basts of examination and/or interest one)  29b. Signature and title of certifier	ath occurred at the time, date nvestigation, in my opinion, 29c. License numb	, death occurre	ed at the time, date	e(s) and mar and place, a Date signed	of eub bn	the cause(s)
)	<b>⊢ ≯ ⊢</b> ŏ		· / Com	D 26	3800	5 1	vill	544	2005
اف	Sta Regist		In. Date filed (Mentin, Day Year)  APR 18 2005  32. Registrar's Signature	specker	K	rgente	كدم		51742

DHMH 17 Rev 1/2001

Registrar

APR 1 3 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) Month **Physician**  $\mathbf{P}^{\mathsf{M}}$ APRIL 8, WASHINGTON 2005 5:40 **ELIZABETH** М. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City Town, or Location of Death Examiner MONTGOMERY MANOR CARE NURSING HOME CHEVY CHASE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 YF Yrs. 1924 **GEORGIA** Director 80 JUNE 29, 253-20-8710 Usual Residence of Decedent the Maryland 10c City Town or Location 10d Inside City Limits 10a State 10b County 28e-f show Examiner must be notified at 1 ▼ Yes 2 No Directo MONTGOMERY GAITHERSBURG MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 Items 23a 718 OUINCE ORCHARD BLVD. APT.T1 20878 U.S.A. death v Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Ie marked other than "natural", or Ite ☐ Yes 2 X No Yes, Give 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Completed by 3 ☐ Widowed 4 ▼ Divorced Year or Dates BI.ACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) or other treumatic event, the Medical 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) FEDERAL EMPLOYEE DEFENSE MAPPING AGENCY 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BEATRICE HEATH IINKNOWN ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN W. FISHER/DAUGHTER 85th PL., NEW CARROLLTON, MD. 20784 6003 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Importent: If It, any injury or o 1 Donation 5 ☐ Other (Specify) MARYLAND NAT'L. CEM. 4-14-2005 LAUREL, MD. 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P. A. 21. Signature of Funeral Service MO0091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ALZHEIMER'S DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit HYPERTENSION that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical HYPOTHYROIDISM IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Year for Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ be 1 Tes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an pace 2 autopsy perform 1 ☐ Yes 2 X No funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Certification: After 5 Pending investigation 1 X Natural 2 ☐ Accident after death. 1 Yes 2 No 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

Box 68760 P.O. Records. of Vital Hospitel or Attending Physician: Division filled in by To the Hospitel within 24 hours a To the Funerel I

29b. Signature and title of certifier

and manner stated

29c. License number

D20274

29d. Date signed (Month, Day, Year)

APR. 11, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7710 BRADLEY BLVD., BETHESDA, MD. 20817 KIRTI VOHRA, M.D.

31. Date filed (Month, Day, Year)

3 2005



State

Registrar

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Dieath Month Day Year **Physician** MARILYN LOUISE WESTERGARD APRIL 9 2005 8:45 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CORSICA HILLS NURSING HOME CENTREVILLE QUEEN ANNE'S 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 🗵 F 76 Yrs. 132-22-9563 June 9, Director 1928 New Jersey Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits r items 23a or 28a-f show there was be notified at 1 ☐ Yes 2 No MD Completed by Funeral Director Queen Anne's Stevensville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 219 Love Point Avenue Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or items 23 21666 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22€ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: 3 ☐ Widowed ♣ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, I'm Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Case Worker 12 Social Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick Gederberg Florence Frieman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trat once. 141 Riverview Avenue Annapolis, MD 21401 Chris Westerguard 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4/11/05 1 Burial 25 emation 3 Removal from State Chesapeake CremationCenter LLC <sup>¹</sup> 4 □ Donation 5 Other (Specify) Stevensville, MD 21. Sign the of Junetal Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final Lung Pnysician years Lancer disease or condition resulting in death) /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): sician Box 68760, Physician/Medical attending phy: IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by Spyradire pulmonen Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. Funeral Director: After t Certification: 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifiers 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Dr. Crowley

610 Dutchmans Lane Easton, MD. 21601

200 32. Resetrar's Signature

			State of Maryland / D	•	rtment of He		-	5 0	See her	t i m t o
			Registrar  1. Decedent's Name (First, Middle, Last)	Oen	meate of E	Calli	2. Date of De	Reg. No.	U5-	3. Time of Death
	Physicia	an					Month	Day	Year	M
	/Medic		Frederick R. Wilcox  4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or I	ocation of Deat	<u>4</u>	0.4 4c. Cour	05 nty of Death	10745
	Examin	er	Suburban Hospital		Bethesda				ıtqome	ru
	E series .		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	thday)		If Under 24 Hrs	8. Date of Bir			place (State or Foreign
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			Usual Residence of Decedent				Squaine	L 1,194C	) that )	rand
	/land		10a. State 10b. County 10c. City, Town		ation					10d. Inside City Limits
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	3a o	Q I	28421 Honeysuckle Drive		20832	2		United	l Stat	es
	death with the Maryland ms 23a or 28a-f ehow rmust be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S.	13. W	as Decedent of His	panic Origin? (S	pecify Yes or No		ace - Ameri	
0	after or Ite		Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	1	Yes, specify Cuban		to Hican, etc.)	:	lack, White,	
212-0030	within 72 hours after ene. than "natural", or Ite he Medical Examine	þ	3 ☐ Widowed 4X Divorced If Yes, Give Year or Dates:	11	□Yes 2XXNo	Specify:		Spe	cify: WN	ite
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and	be filed within 72 hours after death with the Marylar Hygione. d other than "natural; or items 23a or 28a-f ehow event, the Medical Examination must be notified at	Be (	17. Father's Name (First, Middle, Last)				me (First, Middle			
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Mar	permit. Pages 1 and 2 should be Deperment of Health and Mental importent: if I lem 27 Is marked any injury opother treumatic events.		19a. Informant's Name/Relationship (Type, Print)  Margaret A. Wilcox/ Sister  19b. 44	Mailing 112 (	Address (Street at Cannes La	nd Number of Ri ane, Oln	ural Route Numb ey, MD	20832	vn, State, Zij	o Code)
ā,	Hea Hea tem		20a. Method of Disposition 20b. Place of	Disposi	ition (Name of		Date	20c. Locatio	n - City or T	own, State
9	9 2 3 3		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GCO. W '4 ▼ Donation 5 ☐ Other (Specify) Madica	lash	univers	ity Apr	il 8 05	Washin	aton.	D.C.
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a	Dep Impo		13 Just - Clerds		P.	O. Box	58007 Wa	ashingt	ion, D	.c. 20037
			23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	not ente	r the mode of dying	, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
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_			Cheryl A. Aylesworth 6410 Re			r. #65	0 Beth	esda,	MD 2	0812
	Sta	ate	31. Date filed (Month, Day, Year) . Registrar's Signature							
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Year **Physician** Carolyn 0 Wright 2005 10:00 A April 12, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 😾 F Yrs. Director Maryland 578-40-4044 April 2, 1931 74 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b Counts 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ▼ No rector Montgamery Silver Spring Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ā 3386 Chiswick Court, #50-1B 20906 or itams 23a U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Legal Secretary permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygie
Important: if item 27 is marked other ti
any injury or other traumatic event, tri
once. Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John S Whitt Bessie G Cannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacob Lockwood Wright, Jr. / Husband 3386 Chiswick Court, #50-1B Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【\*\*Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory April 14,2005 Alexandria, VA 22. Name and Address of Facility Francis J. Collins FuneralHome, Inc. 21. Signature of Funeral Service Licensee Solve 500 University Blvd, West, Silver Spring, MD 20901 CMD 5 Approximate Interval Between Onset and Death 23a. Part1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final LUNG CANCER Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (classification) Due to (or as a consequence of) Examine as the burial-transit Cause (Disaase or i that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Box 68760 death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes 1 Yes 2 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral ( 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Pint) with LFW 6. FEXRES MED. 3305 Nor Me horsum hinds out of Vace S (Ver DVing Many land 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001

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	rylan	how	_	10a. State 10b. County	1	I0c. City, Town	or Location					1	10d. Inside City Limits
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5	Baltimore, Maryland bernit. Pages 1 and 2 should be file	raum raum		19a. Informant's Name/Relationshi									Code) 21663
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7	it. Pe	njury	f	<ul> <li>4 □ Donation 5 □ Other (Sp.</li> <li>21. Signature of Funeral Service L</li> </ul>		носкеѕ			y   Apr 1 of Facility Cha				, Delaware
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	SiO tandi	tor: A	cati	2 ☐ Accident investigation in	ation		М		es 2 No				
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	ppital	filled		29a. Certifier 1X Certifying	Physician: To the best of	my knowledge	death occurrer	1 at the time	date and place	and due to the o	ause(s) and	manner as s	tated
	• Ho:	e Fur letely	edical	(Check only 2 Medical E	xaminer: On the basis of e and manner state	xamination and	Vor investigatio	n, in my opi	nion, death occurr	ed at the time, o	late and pla	ce, and due to	the cause(s)
	To th	To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Me	29b. Signature and title of certifier	17			c. License	number	2	29d. Date sig	gned (Month,	Day, Year)
					Horou.	Laure	In	D	55484	4	4.	-12 -	- 2005
	,			30. Name and address of person v	no completed cause of dea	ith (Item 23a) (	Type, Print)						
		1		Dr. Harou Laur			ngton S	st. E	aston, M	D 2160	1		
		Sta Registr		31. Date filed (Month, Day, Year)  APR 1 5 2	32. Registrar		harte						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Alvin Wallace 2005 April 11, 2044 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert Months Days Hours Min. Nov. 3, 1941 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Mary land 215-36-3101 1**X** M 2□ F 63 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Maryland
10e. Street and Num
6295 1 Yes 2 No Calvert St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6295 Broomes Island Road 20685 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Quality Control Spec1st. Public Works 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wallace Irene Brown James ٩ 19b Nailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $6295\ Broomes\ Island\ Rd$  . 19a. Informant's Name/Relationship (Type, Print) Lucy Wallace/Wife S.t. Leonard, MD 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Chelt. Vets. Cem. 4/18/05 Cheltenham, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Fred., MD20678 21. Signature of Funeral Service Licensee Sevell Slady U 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner reoscle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Plica Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. be detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown certificete has been si rector, page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Hospital or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: ER/Outpatient 2 1 Yes 2 No After this of 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 28c. Injury at Work? Injury 1. Natural 5 Pending within 24 hours after death. To the Funeral Director; A м 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) ro the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day Year) 30. Name and address of person who complete T cause of death (Item 23a) (Type, Print) Jonathan Lowenthal, M.D. Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) APR 1 5 2005 32. Registrar's Signature State Registrar Davie !

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	Funeral Director		5. Social Security Number 215–64–6888	6. Sex 7. Ac 1 X M 2 □ F 4€	ge (In yrs. last birthda) Yrs.	y) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, July 6,	Year)	9. Birthplace (State or Foreign Country) Kansas	
	aryland show dat	Ţ	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	Location				10d. Inside City Limits	
	n the M	Director	MD Prince	e George's Co	d. Temple	Hills 10f. Zip Code		10	g. Citizen of WI	1 ☐ Yes 2 No	
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36	permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show may injury or other traumatic event, the Modical Examinar must be notified at Once.	y Funeral	11. Marital Status  1 X Never Married 2 ☐ Mari 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' ned 1 ☐ Yes 2 X	? [No	B. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Specan, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race	- American Indian, , White, etc. White	
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<u>Va</u>	Ment Ment arked atic e	10	David W. Watt				Ramona J				
, Mar	and 2 sho salth and n 27 is m or traum		19a. Informant's Name/Relations Monica A. May	ship (Type, Print) (Sister)			tand Number or Rura. USSET Driv			ryland 29754	
Jore	Pages 1 and the part of He ant: If item ury or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 □Removal from State	cemetery, cr	position (Name of rematory or other pla	_			City or Town, State  Maryland	
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<b>f</b> <	Q 55	To B	examiner? 1 □XYes 2 □ No	Hospital: 1 ☐ Inpat	tient 2 XER/Outpati	ient 3□ DOA	ther: 4 Nursing Hon	ne 5 Reside	nce 6 Other	(Specify)	
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	8		THEVOUR	who completed cause of	<i>V</i>	pe, Print) 111	Penn Stre	et Balt	timore,	Maryland 21201	
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05-2907 B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 5 per fh 8842 4-29-05 vt.
State of Maryland? Department of Health and Mental Hygiene UNKNOWN Brandon Allison 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL **Physician** BRANDON ALLISON 26,2005 2125 IARON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY HOSPITAL BALTIMORE CITY NIA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number 220-94-4362 6. Sex **Funeral** Days Year) 1**⊠**M 2□F 24 Hours Director Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "naturel", or Items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 Nes 2 No Directo MARYLAND 10e. Street and Number 10g. Citîzen of What Country? 202 TIMORE by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after Heelth and Mental Hygiene. em 27 Is marked other then "naturel", or Ite 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yas 2 ☒ No 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) COOK HIGRADE MCDONALDS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KEITH ALLISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heelth Item 27 I 2021E, PALTO, MD. 21231 BALTIMORE ST. APT 2B 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
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any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State CEMETERY 105-04-05 ^ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BROWN LANSLOWNE 21. Signature of Funeral Service Licensee JR. FUNERAL HOME JOSEPH 2140 N. ietrec TON AVE 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Enysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached for 9☐ Unknown 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \sum No 24a. Was an certificate has autopsy performed 2 🗆 No To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner?
1 X Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3 □ DOA 1 Inpatient this After thi 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 7105 1 Yes 2 No within 24 hours after death. To the Funerel Director: A completely filled in by the fu investigation 05 2 Accident filled in by the 3 Suicide 4 Homicide 6 Could not be determined 28f. Location (3 reet and Number or Rural Route Number, City or Dwn, State) Place of Injury - At home, farm, street, factory, office (Specify) 3N 8T Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatu 29d. Date signed (Month, Day, Year) 29c. License number of certifier APRIL 27, 2005 O.C.M.E

State Registrar 31. Date filed (Month, PR2 9 2005

ompleted cause of death utem 23a) (Type, Print)

111 PENN STREET, BALTIMORE, MARYLAND 21201

32. registrar's Signature

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			For State	State of Maryland /	•		ntal Hygiene	•	
			State Registrar		Certificate o		Reg. No.	0.05	14548
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deputriment of Heatih and Mental Hygiene. Importance of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ahow any njury or other traumatic event, it a Macical Examinatinatia and 2056.		1 N Burial 2 □ Cremation 3 □ R • '4 □ Donation 5 □ Other (Specify)	emoval from State	1 1 1	rt 4-29-	05 BC	ku. 12	MO
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Limise Anderson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2005 arthou **Physician** Abigi April 27 9:30 AM /Medical 4a Facility Name (If not institution, give street and number, 4b. City, Town, or Locetion of Death 4c. County of Death Examiner Augsburg Lutheran Home Baltimore Baltimore If Under 1 Year Months Days Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 ☐ M 2 🖾 F Yrs. 219-03-6619 04 Director 86 1918 Dec. Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mantal Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumstic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits tX☐ Yes 2☐ No Funeral Director Maryland Baltimore Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? 6811 Campfield Road 21207 USA 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White Specify: Be Completed by 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Household 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clarence Α. Romberger Virginia Hoffmeister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Helen Childs (sister) 407 Sycamore Road, Linthicum, MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Apr **วิ**เรา 29 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 2005 Baltimore, Maryland 21. Signature of Funeral Service Libense 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the dis as shock, or heart failu t ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cluse of each line. Approximate Interval Between Onset and Death se, or complicate. List only one **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the buriel-trensit or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 € No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificeta t 25 No 1LI Yac 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Medical Certification: To 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) After this funerel of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 TYes 2 TNo ours after death. seral Director: A fillad in by the fu death. investigation 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely fillad in 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner es steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier

State Registrar DHMH 16 Rev 6/95

Maun

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2005

MD

32. Regitrar's Signature

Jet

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev Physician 7:40am Beatrice E. Amyx 4/22/05 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Locetion of Death 4c. County of Death Examiner Crofton Convalescent And Rehab Center Crofton Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Deys Min. 576-18-9852 1 ☐ M 2 🖳 📆 84 Yrs. Director 07/09/1920 NJ Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Merylend nent of Health end Mentel Hygiene. Att if Item 27 is marked other than "natural", or items 23s or 28s-f ahow 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 TNo Director MD Prince Georges Bowie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 12611 Bunting Lane 20715 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White δ Specify 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 4 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Be George A. Hagedorn Beatrice Morash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) George R. Amyx / Son 12611 Bunting Lane, Bowie MD 20715 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State important: if it eny injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Bay View Crematory April 25, 2005 Baltimore MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Victor P. Doda, Jr. Charles L. Stvevens Funeral Home, Inc. 1501 E. Fort Ave., Baltimore MD 21230 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner nding physician and use as the bunel-transit or Attending Physician: The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, entia Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown ģ icete hes been sig r, pege 2 should b 24b. Were autopsy findings available prior to Be Completed 24a. Was an autopsy performed? completion of cause of death? 1L Yes 20040 1 ☐ Yes 2 ☐ No certificete 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After this funeral d 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑Natural 2 ☐ Accident 5 Pending deeth. 1 ☐ Yes 2 ☐ No investigation filled in by the within 24 hours efter deet To the Funeral Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MONG D2010 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar Rakesh Arora,

31. Dete filed (Month, Day, Year)

APR 2 9 2005

32 Registrer's Signature

14300 Gallant Fox Ln, Suite 222, BOwie MD 20715

State of Maryland / Department of Health and Mental Hygiene

		1	1 - State of Maryland / Departm	nent of Health and M cate of Death	ental Hygie	2000	14552
	Physicia /Medic	ın	1. Decedent's Name <i>(First, Middle, Last)</i> William Hamilton Brown		2. Date of Death APRIL 20	Day 2005 <sup>ear</sup>	3. Time of Death 6:49 P M
	Examin	er		City, Town, or Location of Death		4c. County of Death	
	Funeral Director			Under 1 Year   If Under 24 Hrs.   8. Date of Birth Malyonth, Pay, Ye	9. Birthp Cour	olace (State or Foreign otry) NY	
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	n		1	0d. Inside City Limits
	Maryl	tor	MD Anne Arundel Glen Burnie	!			1 ☐ Yes 2/XNo
	h with the	al Director	10e. Street and Number 221 Wilson Blvd	of. Zip Code 21061	10g.	. Citizen of What Cour USA	ntry?
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heatth and Mental Hygiene. If item 27 is marked other than "neturel", or Items 23e or 28a-f show or other treumatic event, the Medical Examinat must be rediffed at	by Funeral	1 ☐ Never Married 2 P Married 1 D Yes 2 ☐ No	Decedent of Hispanic Origin? (Spe s, specify Cuban, Mexican, Puerto (es 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: B1a	etc.
21215-0036	hin 72 hour s. in "neturel Medicul E.	Completed	15. Decedent's Education (Give kind (Give ki	s Usual Occupation of work done during most of worki IOT use retired)	ng	b. Kind of Business/In	
	filed wit Hygiene other tha	Com	12 Logisti	cs Specialist		U.S. Army	
land	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, Its IV.	To Be	17. Father's Name (First, Middle, Last)  Jack Horace Brown	18. Mother's Name Arelia M	<i>(First, Middle, M</i> ai orehead	iden Sumame)	
Maryland	nd 2 should lith and Men 27 Is marke r treumatic	-		ddress (Street and Number or Rura Son Blvd Glen B			Code)
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre		20a. Method of Disposition  1  Burial 2  Cremation 3 Removal from State  1  Donation 5 Other (Specify)	ry or other place)		c. Location - City or To	
Balti	permit. Departm Importe any inju			Train Hwy, SW,		nie, MD 21	061
	Fnysician /Medical Examiner		23a. Part Enter the disease or complications that caused the death. Do not enter the shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	e mode of dying, such as cardiac o	or respiratory arrest		Approximate Interval Between Onset and Death
8760, 🗸	death certificate be executed e attending physician and of for use as the burial-transit	dicai Examiner	fi any, leading to immediate cause. Enter Underlying Cause (Disease or in-flus) that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				
.O. Box 6	ne death certiff the attending hed for use as	Completed by Physician/Me		opic pregnancy Her (specify)		23d. Date of delive Month	ery Day Year
α.	n requires that the been signed by should be detact	ed by Pr	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.		cco use contribute to the	
Vital Records,	The law ate has b page 2 st	e Complet	25. Was case referred to medical	26. Place of Death	24a. Was an autopsy performed 100 Yes 2	d? prior to co	psy findings available impletion of cause of 2 No
f Vi	d is <b>y</b>	To B	examiner? 1 X Yes 2 No Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3	Other		e 6 □Other (Specif	y)
Division of	To the Hospitel or Attending Phymibin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	27. Manner of Death  1 Natural 2 Accident  3 Suicide 4 Homicide  28a. Date of Injury (Month, ay Year)  28b. Time of Injury (Month, ay Year)  28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28c. Place of Injury 28b. Time of Injury 28c.	Work? 1 □ Yes 2 No factory, office	28d. Describe how Sulp of a 28f. Location (Street City or Town, S	at and Number of Rura State) 685 0	Port. 2 Serthe
	ne Hospit n 24 hours ne Funera	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occ and manner stated.  28 Medical Examiner: On the basis of examination and/or investigation.	curred at the time, date and place,			tated.
	To the Youthin To the Comp	Me	29b. Signature and title of certifier	29c. License number		. Date signed (Month,	
	0,		Theoder My King was	OCME	Al	PRIL 21, 20	JU5 
	10		30. Name and address of person who completed caute of death (Item 23a) (Type, Print	111 Penn Stree	et Balti	more, Mary	land 21201
	Sta Registi		31. Date filed (Month, Day, Year)  APR 2 9 2005  32. Registrar's Signature	de			

			For State	State of Man	yland / i	•	rtment of H			2000	1
_			* Registrar			Cer	inicate of L	Jean	2. Date of Dea		
	Physicia	an	Decedent's Name (First, Middle, Last)						Month	Day Year	3. Time of Death
	/Medic		Gerard G. Benl						April_		
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, or	Location of Death	1	4c. County of Dea	ith
			Mariner Health of			- I	Caton:	sville	0.000	Baltimo	
	Funeral		5. Social Security Number 6. Sec	x 7. Age (/. Mg 2 ☐ F	In yrs. last bi	Yrs.	Months Days	Hours Min.	(Month, Day	y, Year) 9. Bi	rthplace (State or Foreign ountry)
	Director		212-26-2212 Usual Residence of Decedent		77	113.			April	25,1928 Mai	ryland
	and **		10a. State 10b. County	10	Oc. City, Tow	n or Loc	ation				10d. Inside City Limits
	/any	ō	Manyal and Horrand		17.1.1						1 ☐ Yes 2X No
	28a-	Director	Maryland Howard  10e. Street and Number		LL	LICO	tt City 10f. Zip Code			10g. Citizen of What C	ountry?
	with		3129 Wheaton Way	Apt E			2104	. 2		U.S.A	•
	eath	era		12. Was Decedent Eve	er in U.S.	13. V			pecify Yes or No-		
	ter d	Funerai	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☑ Yes 2 ☐ No		If	as Decedent of Hi Yes, specify Cuba	n, Mexican, Puert	o Rican, etc.)	Black, Wh	ite, etc.
8	urs a	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	WW II	1	☐ Yes 2½ No	Specify:		Specify:	hite
ŏ	2 hou	Completed	15. Decedent's Edu	cation	16a	. Deced	ent's Usual Occupa	ation	4.1	16b. Kind of Busines	
72	7 nin 7	ple	(Specify only highest grad	College (1-4or 5+)		life. D	kind of work done of O NOT use retired	unng most of wor )	King		
2	d with	E	Elementary, Secondary (S-12)	2	Fe	dera	al Protec	tive Off	icer	Law Enforc	cement
פ	othe vent,	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	
<u>a</u>	Alenta Alenta rked tic •	70	Gerard Joseph Ben	kert				Ethel Hu	ınt		
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Heelth and Mental Hygiene. Item 27 is marked other than "natural; or Items 23a or 28a-1 show other traumatic event, the Medical Eventher must be notified at	ir i	19a. Informant's Name/Relationship (T)	rpe, Print)	191	b. Mailin	g Address (Street a	and Number or Ru	ıral Route Numbe	er, City or Town, State.	Zip Code)
Σ	elth elth 27 i		Edith A. Benkert	(Wife)	31	129	Wheaton W	lay Apt I		ott City, 1	MD 21043
ore	of He of He roth		20a. Method of Disposition		20b. Place o	of Dispos	sition (Name of atory or other plac	e)	Date	20c. Location · City o	r Town, State
Ē	Page nent int: If		1 XBurial 2 ☐ Cremation 3 ☐ F  1 4 ☐ Donation 5 ☐ Other (Specify)		Garri	son	Forest C	em. 4-2	27-2005	Owings Mil	lls, MD
Baltimore,	permit. Pages 1 and 2 Department of Heelth a Importent: If Item 27 is any injury or other tre-		21. Signature of Funeral Service Licens	:00		22	Name and Addres	s of Facility	<del>-</del>		
ä	E E E S	1	Mile 1/2	1		16	itzke rui 30 Edmond	lerai nom Ison Ave	ne or ca Catons	tonsville, ville, MD	inc. 21228
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused th	e death. Do						Approximate Interval Setween
	Pnysician		Immediate Cause (Final	M4	12	Lah		tric C			Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a c	consequence	of):	0700	mcc	204700		WM
	Examiner			·		. ,					
		ě		b. Due to (or as a c	consequence	of):					
	uted d ansit	Examiner	if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events	c							
ó	exec en an rial-tr	EX	resulting in death) Last	Due to (or as a c	consequence	of):					
8760,	icate be executed physicien and s the burial-transit	dicat		d							
9		0								1	
Вох	h cer endin	N/N	23b. was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2 [		h 3	Ectopic pregnancy			23d. Date of de	
ω.	deat	icia	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at tin			Other (specify)			Month	Day Year
Ö.	that the death certifi ed by the attending I detached for use as	Physician/M	9 🗆 Unknown	9LI ONKNOWN							
o,	The law requires that the death certifi ate has been signed by the attending page 2 should be delached for use as	by P	Part II. Other significant conditions co	ntributing to death but i	not resulting	in the ur	derlying cause give	en in Part I.	23e. Did to	obacco use contribute	
ğ	w require been si			Cer.	<i>D</i>				1 🗆 1	Yes 2 □ No 3 □ F	robably 4 Ponknown
Vital Records,	e law requ has been le 2 should	Completed		A. 5	6				24a. Was		utopsy findings available completion of cause of
ď	The I	E		Colo	~ C	zme	er		perfo	rmed? death?	
ta		(D)	25. Was case referred of medical					26. Place of Dea	ath (Check only o	one)	
>	ysiclan: is certific director,	To B	examiner? 1 \( \text{Yes} \) 2 \( \text{Yes} \)	Hospital: 1   Inpatient	2 🗆 ER/0	utpatien	t 3□ DOA Oth	er: 4 Vursing H	lome 5 Resid	dence 6 □Other (Sp	ecify)
o t	Attending Physician: r death. sctor: After this certific by the funeral director,		27. Mann of Death	28a. Date of Injury (Month, Day Y	(ear) 28b.	Time of Injury	28c. Injun Worl			now injury occurred	
jo	ath. r: Afr	atio	1 Vatural 5 ☐ Pending 2 ☐ Accident investigation	(	,	,,		Yes 2 □ No			
Division	Atte er de recto by th	iii e	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	/ - At home, f	arm, str	et, factory, office		28f. Location (S City or Tox	Street and Number or F vn, State)	Rural Route Number,
Ö	talon rseft al Din ed in	Certification:								-	
	To the Hospital or Attend within 24 hours effer death To the Funeral Director: completely filled in by the			sician: To the best of a							
	ths H in 24 the F iplete	ledical	one)	and manner state			1				
	Vith To 1	Σ	29b. Signature and title of certifier	10 -	17/1	V L	29c. Licens	9 / 9 ( / '	2	29d. Date signed (Mor	
)	~		Mada	for V.	- /	D	1	5617	_	11/2/ 52	, 2005
	1/8		30. Name and address of person who c				. 1 03	- 1			
			B. TURAKHIA,	ND 1009	1 / '	der		Cator	youle,	MD 2122	8
		ate	31. Date filed (Month, Day, Ypape 9	9 2005 Registr	s Signature	L	Soule				
	Regist	rar	1012	3 4000 M	Buch	J.	GOSHA!				

		-	For State Registrar	State of	Marylan	-	artment of F		d Mental Hy	giene Reg. No. 2 ()	05	11.551.
			Decedent's Name (First, Midd	lle, Last)					2. Date of De	ath		3. Time of Death
	Physicia		Marv	Lee	Bacon				April	27200	Year	11:00 PM
	/Medic Examin		4a. Facility Name (If not institution	on, give street and num	iber)		4b. City, Town, o	r Location of D		4c. County		11.00 111
п			6828 Leslie R	oad			Middle	River		Bali	timor	e
	Funeral		5. Social Security Number	6. Sex 7	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Di	ay, Year)	9. Birthp	lace (State or Foreign
	Director		217-30-2927 Usual Residence of Decedent		70	Yrs.			Dec. 3	0, 1934	Mar	yland
	land ow		10a. State 10b. Count	у	10c. Cit	y, Town or Lo	ocation				1	0d. Inside City Limits
	Many s-f sh	to	Maryland Balt	timore		Middle	River					1 □Yes 2 X No
	or 288	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	itry?
	23a	la	6828 Leslie Ro	oad			2122	20		U.S	.A.	
	er dez	Funeral	11. Marital Status	12. Was Deced	ces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	14. Rad Blad	e - Americ ck, White,	
36	s afte	by F	1 ☐ Nøver Marriød 2 ☐X Ma 3 ☐ Widowed 4 ☐ Divorcø	If Yas Give	9 ^		1 ☐ Yes 2 🙀 No	Specify:		Specify	. Wh	nite
21215-0036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show Edical Evantiner must be notified at			nt's Education		16a. Dece	dent's Usual Occup	pation		16b. Kind of B	usin <i>e</i> ss/fno	dustry
215	<u>_</u>	plet	(Specify only higher Elementary/Secondary (0-12)	est grade completed)	40r 5+\	(Give	ki⊓d of work done DO NOT use retired	during most of d)	working			,
21	filed within Hygiene. Ither then "	Completed	12 yr's	College (1		Н	ome Maker	•		0wn	Home	
nd		Be	17. Father's Name (First, Middle		<b>4</b>				Name (First, Middle	, Maiden Suman	10)	0
Maryland	Men Men mrke arke	P	Leo F.  19a. Informant's Name/Relation	McGini	Ly	19h Maili	na Address (Street		zabeth r Rural Route Numb	er City or Tourn	State 7in	Codal
	Ta ha		Francis X. Bac		ind		828 Lesli			-		
ē,	s 1 and of Healt Item 2 other		20a. Method of Disposition			Place of Dispo	osition (Name of matory or other place	ce)	Date	20c. Location -		
Ë	Pages nent of I ant: if Its ary or o		1 Burial 2 Cremation 4 Donation 5 Other (		erare	Holly	-	. 1	pr. 30,20	05 Ralt	imore	MD e
Baltimore,	perrit. Pag Depirtment Important: I any injury o		21. Signature of Funeral Service	e Licensee	0		2. Name and Addre		Baltimor			
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n.			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that ca st only one cause on ea	used the deat ach line.	h. Do not <i>e</i> nt	ter the mode of dyin	ng, such as car	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Pnysician	3 19	Immediate Cause (Final disease or condition	MET	4-0-0	_						
	40.0 44 4		roculting in death)	a. / / /	なりょうし	- 5909	mous CA	ncinom	A NECK	LUNG	- 2	9 mon the
	/Medical Examiner		resulting in death)	Due to (c	or as a conseq	ueno of):	mous CA	newom	A NECK	- LUNC		9 mon tus
		er	resulting in death)	RECE	or as a consequence or a consequence or a conse	- Sau	mous CA	ncinon	4 NECK NA TONG	ue LUNC		
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of Vital Records, P.O. Box 6	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (co. Due	or as a consequence of pregnar the 2 Feta and at time of dwn  ath but not result injury. At high, Day Year)  of Injury. At high, Cay Year  best of my known is so of examina er stated.	uence of .  uence	Ectopic pregnancy Other (specify)  Inderlying cause give  Int 3 DOA  Int 28c. Injury Wor M  Int 28c. Injury Wor Wor N  Int 29c. Licens  D 2-J	ren in Part I.  26. Place of ler: 4 \( \text{Nursing water and population, death of the number} \)	23e. Did  1 24a. Was auto performed to the control of the control	23d. Dar Mo  23d. Dar Mo  23d. Dar Mo  24b. Pormed? 2 No  24b. Pormed? 2	te of delive inth  the of delive inth  The probing the control of	S MUNTHS  S MUNT

		•	For State Registrar	State of Ma	arylan		artment of				giene	005	14555
			Decedent's Name (First, Middle, Last)							2. Date of Dea	ath		3. Time of Death
	Physicia /Medic		Marg	garet	Broo	oks				April	$26^{Day}$	2005	5:00 P.M
	Examin		4a. Facility Name (If not institution, give s	treet and number)			4b. City, Town,	or Location	of Death		4c. C	ounty of Death	
			8805 Stonebridge					sville				Baltim	
n	Funeral		5. Social Security Number 6. Sex 1 1 2 9981	M 2 □XF 7. Age	80 (In yrs. 1	as <i>t birthd</i> ay Yrs.	Months Days		Min.	8. Date of Birth (Month, Day	v. Year)		place (State or Foreign intry)
	Director		Usual Residence of Decedent		00_					May 2,	1924	Wes	st Virginia
	yland yland		10a. State 10b. County		10c. City	, Town or I	ocation						10d. Inside City Limits
	e-fsl	ctor	Maryland Baltimon	re	I	Pikes	ille						1 ☐ Yes 2 🔀 No
	or 28	Oire	10e. Street and Number			100	10f. Zip Code				-	on of What Cou	intry?
	s 23e	Funeral Director	8805 Stonebridg					1208				J.S.	
	itam Itam	-un-	11. Marital Status  1 □ Never Married 2 □ Married	<ol> <li>Was Decedent 8 Armed Forces?</li> <li>1 ☐ Yes 2 ☐ XN</li> </ol>		5. 13	Was Decedent of If Yes, specify Cul	oan, Mexica	n, Puerto I	Rican, etc.)	. 14	I. Race - Ameri Black, White	
21215-0036	tiled within 72 hours after death with the Maryland Hygiene. other then "natural", or Itams 23e or 28e-f show ont, the Medical Examinat must be notified at	þ	3 □Widowed 4 □Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🔀 No	Specify:	:		s	pecify: Wh:	ite
Q 2	72 ho	Completed	15. Decedent's Educ (Specify only highest grade			16a. Dec	edent's Usual Occu	pation	st of working	na l	16b. Kind	of Business/Ir	ndustry
2	ithin and and and and and and and and and an	npie	Elementary/Secondary (0-12)	College (1-4or 5	+)		e kind of work done DO NOT use retire nemaker	9d)	3, 0, 40,7,0,	,g	0	1 Home	
2	iled w dygier ther ti		12th  17. Father's Name (First, Middle, Last)			1101	iciiakci	18 Moth	or's Namo	(First, Middle,			
Maryland	d be f	To Be		Dorsey,	Sr.					a Tharp		umame <sub>j</sub>	
ير	shoul nd Me mark imark	F	19a. Informant's Name/Relationship (Type			19b. Mai	ling Address (Stree	1				Town, State, Zi	p Code)
ž	alth a alth a 27 is		Donald Brooks / H	lusband		8801	Stonebr	idge (	Cir.	Apt.103	Pike	esville	, MD. 21208
ore	of He of He fitam		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re	amoval from State	20b. P	lace of Disp emetery, cr	osition (Name of ematory or other pla	ace)	D	ate	20c. Loca	ation - City or T	own, State
Ĕ	Pag ment lant: l		`4 □Donation 5 □ Other (Specify)	smoval nom otalo	Mt	. 01i	vet Cemet	ery					Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinator and be notified at ODGs.		21. Signature of Funeral Service License	θ	1.		22. Name and Addr						e, P.A.
	FD = 8 0		220 Ports Enter the diseased or compli	mecoul	MA door							e, Mary	Approximate
М	in aff		23a. Part1. Enter the disease or complications, or heart failure. List only on Immediate Cause (Final					1.6					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as			paner	eeti		CCIVIC	en	<b>)</b>	3 mc
в	Examiner				u 00113041	00100 017.							
Ш	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):							
	ecuter and trans	Examiner	Cause (Disease or injury that initiated events cresulting in death) Last										
8760,	death certificate be executed e attending physician and by for use as the burial-transit		4	Due to (or as	a consequ	uence or).							
687	ficate physis the	edical											
Вох	leath certific attending p	N/u	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome							23	d. Date of deliv	rery
	the atte	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No	1□Live birth 4□Pregnant at 9□Unknown			□Ectopic pregnand □ Other (specify)	У				Month	Day Year
P.O.	tac by	Phy	9 Unknown								_		
	es De	b	Part II. Other significant conditions con	tributing to death b	ut not resi	uiting in the	underlying cause g	ven in Part	1.		obaccouse ⁄es 2□		the cause of death? bably 4°  Unknown
Records,	n requires been sign should be	Completed											
Rec	e lay	ш									med?	prior to co death?	opsy findings available empletion of cause of
Vital	ician: Th certificate ector, pag	e C	25. Was case referred to medical					26 Plan	o of Death	1 ☐ Yes (Check only o	300 No	1 🗆 Yes	2 □ No
i N	69 (0 =	0 8	examiner?	ospital:	nt 2 🗆	ER/Outpati	ent 3 DOA	her	ursing Hor	A -		□Other (Speci	fv)
101		n: T	27. Manner of Death  1 SNatural 5 □ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time Injury	of 28c. Inju			28d. Describe h			
Sio	Attanding r death. ector: After oy the fune	catic	2 Accident investigation				M 1	Yes 2□					
Division of	of or Attand after death Director: ,	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, etc	ury - At ho c. (Specify	ome, farm, s	treet, factory, office	•	2	28f. Location (S City or Tow	Street and i vn, State)	Number or Rur	al Route Number,
	lospital of hours at unarel D		29a. Certifier 1 Certifying Phys	icien: To the best	of my kno	wledge de	Ith occurred at the	ime date ar	nd place a	and due to the	calleb(e) a	nd manner as	stated
		Medical	(Check only 2 Medical Examinate)	er: On the basis of and manner sta	examina	tion and/or	nvestigation, in my	opinion, dea	ath occurre	ed at the time, o	date and p	lace, and due t	to the cause(s)
	To the l within 2 To the complet	Me	29b. Signature and live of certifier				29c. Licer	ise number			29d. Date	signed (Month,	Day, Year)
)			· COLLA	MA			DZ	SXS	SY	4	4-2	8-05	
6	9		30. Name and address of person who co	mpleted cause of	eath (Iten	23a) (Type	, Print)	2				0 7	
2	Sta	ito	31. Date filed (MON) Day Year)	2. Registra	ar's Siona	ture	157000	DE	+ LTI	MONE		W 21-	229
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DHMH 17 Rev 1/2001

			1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death  Reg. No. 1 4 5 5 6
	Physicia		1. Decedent's Name (First, Middle, Last)  FREO LEE BRADSHAW  2. Date of Death Month Day Year 2005 8:30 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Bultimore Rehab Est. Care Gater Bultimore  N/A
	Funeral Director		5. Social Security Number 212 14 4120  6. Sex 1 M 2 F 88  7. Age (In yrs. last birthday) 88  Yrs.  1 Months 1 Days 1 Hours 1 H
	Aaryland I show	or	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limits           Maryland         N/A         Baltimore         1™Yes 2□No
	with the Name of 28a-	Funeral Director	10e. Street and Number  10f. Zip Code  10g. Citizen of What Country?  10s. Street  21225  U.S.
036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 ia marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic svent, Ite Medical Experient must be neitlind an once.	by Funera	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 3 Nover Married 2 Nover Married 3 Nover Married 4 Divorced  12. Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  15. Yes 2 No Specify: Specify: White
Maryland 21215-0036	within 72 ho jene. r than "naturi it e Medical I	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 6th  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Carpenter  16b. Kind of Business/Industry Self employed
/land	uld be tile Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last)  UNK  18. Mother's Name (First, Middle, Maiden Surname)  (not available)
	and 2 sho ealth and m 27 la mu her trauma		19a. Informant's Name/Relationship (Type, Print)  Mary Ochs / Granddaughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  3808 - 8th Street Baltimore, Maryland 21225
Baltimore,	permit. Pages 1 Department of H Important: If itel any injury or ottl once.		20a. Method of Disposition  1 \(\mathbb{Z}\)Burial 2 \(\mathbb{C}\)Cremation 3 \(\mathbb{R}\)Removal from State  4 \(\mathbb{D}\)Donation 5 \(\mathbb{O}\)Cher (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Crestlawn Cemetery 4/29/2005  4/29/2005  Marriottsville, MD.  22. Name and Address of Facility  Conce Funeral Service, F.A.
			23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Batween Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death)  a. Due to (or as a consequence of):
8760,	icate be executed physician and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):
P.O. Box 68	death certit e attending d for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
	requires that the een signed by the hould be detache	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
Vital Records,	The larate has	Completed	Chronic Obstructive Pulmonary Dises 24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No
Division of Vita	or Attending Physician: The death. lirector: Atter this certiticate n by the funeral director, pag	ertification: To Be	25. Was case referred to medical examiner?  1   Yes
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely tilled in by the fu	edical Ce	29a. Certifier  (Check only one)  29a. Certifier  29a. Cer
)	To the within 2 To the comple	Med	29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year)
4	115		30. Name and add as of person who completed cause of death (Item 23a) (Type, Print) XIANGRONG SHAD  3900 Local Raven Blvd Ballamore, MD 21218
	Sta Regist		31. Date filed (Month, Day, Year)  APR 2 9 2005  32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 8136 of Merchans 1979 1979 1979 Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death) **Physician** Month Day Year Tannie 2005 /Medical Amelia April Cotton 12:06 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Chester River Hospital Chestertown Kent 5. Social Security Number 8. Date of Birth 02/08/1917 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 1 □ M 20 F Director 217-76-4952 88 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1. Pres 2 □ No Director Texas Tarrant Arlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2007 E. Arkansas Lane 76010 Funeral USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 PNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Black Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Home maker Some one else's home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental Pages 1 and 2 should be George Sisco Carrie Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawn Cotton / Son 2007 E. Arkansas In., Arlington, Texas 76010
ace of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of P
Importent: If ite
any injury or of 1 Denial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aaron Chapel Cem. 04-30-2005 Sharptown, Maryland 22. Name and Address of Facility
Bennie Smith Funeral Home

Street, Dover, Delaware 19904

Approximate 21. Signature of Funeral Service Licensee ammie 2haw 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheinous **Physician** Zyean3 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician e Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death byt not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Bronchiectosis Chronic Brondhitis 1 Yes 202 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has page 2 autopsy performed Vescula D 1 Yes 251 No : After this certification in the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2. No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stoddardmi St. Chestertown MD 100 31. Date filed (Month, Day, Year) 32. Paistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Ragistra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month. Mary Coates 23 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Dita HOS nai If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Yrs. 219-26-7912 70 Director MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 □ Yes X XNo Directo Owings Mills MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21117 Completed by Funeral 4500 Chaircer Way Unit 306 U.S.A. Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. X Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 21 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced Black "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2yrs Claim Authorizer Social Security Adm 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Is marked o Harriette Grant James Z. Coates Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 19a. Informant's Name/Relationship (Type, Print) Item 27 P. Anthony Coates-Brother
20a. Method of Disposition 20b. 4600 Alcott Way, Unit 305, Owings Mills, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important; If Ite any injury or of once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/30/05 \* 4 ☐ Donation 5 ☐ Other (Specify) MD National Park Laurel, Md 21. Signature of Funeral Service License <sup>22, Name and Address of Facility</sup>
March F/H West
4300 Wabash Ave, Baltimore, Md ar 21215 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 6 lone wone phritis -Lmnune disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner ulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2□ No 2 🗆 No Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 Yes 2 No Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attending Natural 5 Pending 1 Natural 2 Accident after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours at To the Funeral D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

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State

Registrar

KBRA

31. Date filed (Month, Day, Year)

7/2/5

THEINOR

APR 2 9 2005

32. Registras Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Day 2005 **Physician** COLLINS ANNABELLE 24, 11:20P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Asbury Methodist Home Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 XX 218-18-4022 Yrs. 85 December 7, Director 1919 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Exercitives must be notified at 1 ☐ Yes 2 ☐ No Director Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? ö 211 Russell Avenue 20877 238 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2000 to If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Itams 11. Marital Status 14. Race - American Indian. filed within 72 hours after Wever Married 2☐ Married Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Non Profit Organization Secretary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill trans of Health and Mental H lant: If item 27 is marked off jury or other traumatic even Be Charles Edward Collins 2 Ida Chason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Chason Cousin 9715 Uxbridge Road Baltimore, Maryland 21234 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of the Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery 4/29/05 □ Donation 5 □ Other (Specify) Baltimore, Maryland ignature of Funeral Syrvice License 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Congestivehear ? /Medical resulting in death) Due to (or as a consequence of): Examiner 4 stereselesotie cardiovanular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 3 Probably 4 Unknown should b 1 Yes 2 ™No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed this certificate ha accident. asculardiscuse 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one Hospital: 1 Yes 2 No Other: 4 Wursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director:: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 1 Decrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) I habertpreschla 104-11 0 1660 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 201 L4SELLALEWILL I ROBERT BIKK (1846 H WIN) GAITHERS BURG, MID XI 31. Date filed (Month PR) 9 2005 32 Registrar's Signature State Registrar

			1 - For State Registrar	State of Maryl			of Health a of Death	•	rgiene Rag. No.2 0 0 5	14560
			1. Decedent's Name (First, Middle, La	ist)				2. Date of De Month		3. Time of Death
	Physici: /Medic		Yong Hui Cin	tron				April	26 200	5 6:10 a M
	Examin		4a. Facility Name (If not institution, gir	ve street and number)		4b. City, Tow	vn, or Location of	of Death	4c. County of D	eath
			Lorien Riverside			Belca	1		Harford	
	Funeral Director		581-19-6141		yrs. last birthday) 4 Yrs.	If Under 1 Y	ear If Under ays Hours	24 Hrs. 8. Date of Bi Min. (Month, Di May 2,	nth ay, <i>Year)</i> 9. 1 <b>1</b> 950 Ko	Birthplace (State or Foreign Country) Drea
	and w		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Limits
	Aaryl f sho	ō	MD 11-6-	1	11					1 ☐ Yes 2X No
	28a-	ect	MD Harfor  10e. Street and Number	<u>d</u>	Aberdeen	10f. Zip Cod	de		10g. Citizen of What	Country?
	with o	ă	2400 N. Post Roa	d		210			USA	
	ours after death with the Marylar ral', or Hems 23a or 28a-f show Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever i	in U.S. 13.			gin? (Specify Yes or No		merican Indian,
	Iten d	5	1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 ☐ Yes 2 🔀 No		If Yes, specify	Cuban, Mexican	n, Puerto Rican, etc.)	Black, W	
36	irs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀	No Specify:		Specify:	Korean
ŏ	72 hours after death with the Maryland "netural", or Hems 23a or 28a-f show offcal Examinar must be notified at	ed	15. Decedent's E		16a. Dece	dent's Usual O	ccupation		16b. Kind of Busine	
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<u>a</u>		To B	Sun Kim				Pak	. Uiryn		
Maryland 21215-0036	S E E	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (St.	reet and Numbe	er or Rural Route Numb	er, City or Town, State	e, Zip Code)
_	and 2 salth a n 27 Is		Dong Jin - husba	nd	2400	N. Pos	st Road,	Aberdeen,	MD 21001	
e e	iges 1 an of Heal If item 2 or other		20a. Method of Disposition		b. Place of Dispo	osition (Name of	of r place)	Date	20c. Location - City	or Town, State
Ĕ	Pages nent of int: If it		1 ☐ Burial 2 XCremation 3 (	ify)				4/27/2005	Beltsvill	e, MD
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice	ensee	2:	2. Name and A	ddress of Facilit	. Lohrmann	TDA	.,'.
m	80 = 8		1 Hall	M0098	36	AFA, St 717 Gre	epnen L en Past	ures Drive	, PA Towson	MD 21286
			23a. Part . Enter the disease, or cor shock, or heart failure. List only	nplications that caused the	death. Do not en	ter the mode of	dying, such as	cardiac or respiratory a	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final		to do	Lie	Polono	10000	neen	Onset and Death
Н	/Medical		disease or condition resulting in death)	Due to (or as a con	sequence of):	1)	1100	MED (OI	VILLEV	
	Examiner				Glade	100	Calco			124 PM
	_	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):					1
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o,	an a		resulting in death) Last	Due to (or as a con	sequence of):					
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9	ng ph	Med	IF FEMALE:							
Вох	attending for use a	an/I	23b. Was decedent pregnant	23c. If yes, outcome of pre 1 Live birth 2 □ I		⊒Ectopic pregn	iancv		23d. Date of	
	ne death the atte	sici	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time 9☐Unknown		Other (specifi			Month	Day Year
P.0	at the di	h.	9 Unknown							
	es that igned t	b	Part II. Other significent conditions	contributing to death but not	resulting in the u	Inderlying cause	e given in Part I.		1	to the cause of death?
of Vital Records,	w requir been si should	ted						1	Yes 2 2 0 3 🗆	Probably 4 Unknown
õ	e law r has be	Completed						24a. Was	an 24b. Were	autopsy findings available to completion of cause of
<b>E</b>		νo						perfo 1 ☐ Yes	ormed? death 2⊠No 1□Y	7
/ita	<u>ii</u>	Be (	25. Was case referred to medical examiner?				26. Place	of Death (Check only	one)	
Ž	hysicle his cert il direct	မှ	1 □ Yes 2 XNo	Hospital: 1 ☐ Inpatient	2 ER/Outpatier			ırsing Home 5 ☐ Resi	idence 6 □Other (S	pecify)
	ding Ph h. After th funeral	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time o		Injury at Work?		how injury occurred	
Sio	Attending ir death. ector: After by the fune	cati	2 Accident investigation			М	1 □ Yes 2 □ I			
Division	or Attendate death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Injury - / building, etc. (Sp	At home, farm, sti ecify)	reet, factory, off	fice		(Street and Number or wn, State)	Rural Route Number,
	ospitel or A hours after unerel Dire y filled in by									
	T 4 T 0	edical	29a. Certifier 1 Certifying P (Check only 2 Medical Exe	hysicien: To the best of my miner: On the basis of exam	knowledge, deat nination and/or in	h occurred at the vestigation, in r	ne time, date an my opinion, dea	d place, and due to the th occurred at the time,	cause(s) and manner date and place, and o	as stated. fue to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. 1 ic	cense number		29d. Date signed (Mo	onth, Day, Year)
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	V		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	erint)	me of	not an	1 Aug 1	un21014
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's	ignature A	a Anos	The state of the s	170	1 1 m)	W1111-10/1
	Registi		AP	R 2 9 2005 56	EUS. C		-			

			. For						and Menta		_	
			For Stata Registrar			Cei	rtificate o	f Death		Rag. I	1200p	4561
П	Physici	an	1. Decedent's Name (First, Middle,						Mor		Day Year	3. Time of Death 945 A M
	/Medic Examin		Earl Martin Care  4a. Facility Name (If not institution,		ber)		4b. City, Town	n. or Location	of Death		4c. County of Deat	
	LXami	CI	Mercy Medical Co		•		Baltim				N/A	
	Funeral			. Sex 1	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Ye Months Day		Min. 8. Date	of Birth oth, Day, Yea	ar) 9. Birt	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent	18.11	48	TIS.			Feb.	1, 19	956   Mar	yland
	yland how		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
	Ba-1 s	ctor	MD N/A		Ва	ltimor	·e					1 ☐ Yes 2 ☐ No
	with the or 2	by Funeral Director	10e. Street and Number 904 Homestead St	reet			10f. Zip Code				Citizen of What Co	untry?
	ne 23	erai	11. Marital Status	12. Was Dece	dent Ever in U	.S.   13. <sup>1</sup>	2121 Was Decedent of		rigin? (Specify Yes in, Puerto Rican, e		JSA 14. Race - Ame	ncan Indian,
ထ္	or itan	Fur	1 Never Married 2 ☐ Marrie	Armed For d 1 Tyes If Yes, Give	2€ No		lfYes,specifyC 1□Yes 2√201			etc.)	Black, White	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f show the Medical Exertirer must be rodified at	d by	3 Widowed 4 Divorced	Year or Da					•	1	<u> </u>	lack
15	in 72 n "nat	Completed	15. Decedent's (Specify only highest	grade completed)	45-)	(Give	dent's Usual Oco kind of work do DO NOT use ret	ne during mo	st of working	160.	Kind of Business/	Industry
212	giene grene er tha	Com	Elementary/Secondary (0-12)	College (1	40r 5+)	Mec	hanic			5	Service C	enter
nd	be file	Be	17. Father's Name (First, Middle, La					_	er's Name (First, I	Middle, Maid		
Maryland	hould d Mer marks matic	2	Norman  19a. Informant's Name/Relationship	Care	∍у	19h Mailir	n Address /Stre		menter	Number Cit	(Unkn y or Town, State, 2	
Ma	nd 2 s lith an 27 is r trau		Anthony C. Worr						, Baltim	_		<i>ip</i> 0000/
Baltimore,	es 1 a of Hea fitam rotha		20a. Method of Disposition  1 Burial 2 Tremation 3	-	20b. F	Place of Dispo	sition (Name of natory or other p	olace)	Date	20c.	Location - City or	Town, State
ij	Pag tment tant: i		`4 □Donation 5 □Other (Spe	cify)	Ra I		Cremat Park		4/27/05		timore,	
Bai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural; or itams 23a or 28a-1 show any injury or other traumatic avant, the Medical Examinating Learcilited at ance.		21. Signature of Funeral Service Li	OHSHO		22					Funeral e, MD 21	
	M 1539		23 . First. Enter the disease, or co	omplications that ca	used the deat	h. Do not ent					e, m 21	Approximate
	Physician		shock, or heart failure. List or Immediate Cause (Finat disease or condition	ny one cause on ea	ich line.	e ad	and	0.	ech co	ner		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (	or as a conseq	uence of):	00,10					
П	Lammer	-	Sequentially list conditions,	b. — Supertraft	r as a consec	инпер об:						
V	uted d ansit	Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			,						
,092	ate be executed hysician and the burial-transit	Еха	resulting in death) Last	Due to (	or as a conseq	uence of):						
	cate bo	dical		d								
89 xc	death certifical e attending phy d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo							23d. Date of deli	verv
Box	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		rth 2 ☐ Feta ant at time of d		Ectopic pregnal Other (specify)				Month	Day Year
P.O.	at the	Phys	9 Unknown							Didast		
ds,	8 5 9	by	Part II. Other significant condition	s contributing to de	ath but not res	uiting in the u	nderlying cause	given in Part	1, 238			the cause of death?
Record	> 12 (A)	letec							24a	. Was an		topsy findings available
Re	The law ate has b page 2 st	Completed								autopsy performed? Yes 2	prior to death?	ompletion of cause of
Vital	ıysician: Th iis certificate director, pag	BeC	25. Was case referred to medical examiner?						e of Death (Check		10 12100	
of \		P.	1 ☐ Yes 2 ☐ No  27. Manner of Death		patient 2	ER/Outpatien	I SU DOA	The second second	_		6 ☑Other (Spec	ity) hospice
	Attending I r death. actor: After by the funer	tion	1 Natural 5 Pending 2 Accident investiga	28a. Date of (Month)	Day Year)	Injury	V	york? □Yes 2□		scribe now in	jury occurred	
Division	Atter actor by the	Certification:	3 Suicide 6 Could no determin	288. Place	of !njury - At he g, etc. (Specif	ome, farm, str	eet, factory, offic	CB		ation (Street or Town, Sta	and Number or Ru	ral Route Number,
ā	itai or urs afte rai Dir											
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral directors.	edical	29a, Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the taminer: On the ba and mann	sis of examina	wledge, death tion and/or in	occurred at the vestigation, in m	time, date a y opinion, dea	nd place, and due ath occurred at the	to the cause time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the Compl	Me	29b. Signature and title of certifier				29c. Lice	ense number		29d. [	Date signed (Month	, Day, Year)
)			DV M				DH	0854			1/25/2	200
	1		30. Name and address of person wi	no completed cause	of death (Iten	n 23a) (Type,	Print)	. ( '	1		1	
	Sta	te	31. Date filed (Month, Day, Year)	20 32. Re	egistrar's Signa	MGUI iture	MI DO	11 dimi	ore mod	. </td <td>202</td> <td></td>	202	
*	Registr		APR 2 S	2005	Beauce	K	(int)					

DHMH 17 Rev 1/2001

			For State Registrar	State of Mar	yland / Dep		lealth and M	lental Hygi	ene	05	1456
¥ =	Physicia	an	Decedent's Name (First, Middle, La	·				2. Date of Death Month	Day	Year	3. Time of Death
1	/Medic	al	Francis X. Cunn  4a. Fecility Name (If not institution, gin			45 City Town	- Landing of Booth	April 26	4c. County		2:00 A M
	Examin	er	1003 Jackson B1			Bela:	r Location of Death		Harf		
	Funeral		Social Security Number 6.	Sex 7. Age (	In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			ace (State or Foreign
E &	Director		217-18-3175 Usual Residence of Decedent		81 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 8/25/19	23	Mar	yland
rrylan	wow	_	10a. State 10b. County		Oc. City, Town or L					10	d. Inside City Limits
he Ms	Ba-f	Director	MD N/	'A	Baltimo						1 ⊈Yes 2 No
with t	Den.	Ē	10e. Street and Number 5921 Eurith Ave	enue		10f. Zip Code	1206	10	g. Citizen of V		ry?
death	me 20	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.		lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-	14. Rac	e - America	
<b>036</b>	and Mental Hygiene. Is marked other than "natural", or Itame 23a or 28a-f show aumatic event, the Medical Examinat must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3X Widowed 4 ☐ Divorced	Armed Forces?  12 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cubin	an, Mexican, Puerto Specify:	Rican, etc.)	Specify	k, White, e	
Baltimore, Maryland 21215-0036	an "natur Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation rade completed) College (1-4or 5+)	(Give	edent's Usual Occup e kind of work done DO NOT use retire	during most of worki	ng 16	6b. Kind of Bu	usiness/Ind	ustry
21.8 Wit	giene er thu	Com	12		1 .	ounting &			A.R.D.		
and d be file	ed oth	Be	17. Father's Name (First, Middle, Las. Raymond Cunning				18. Mother's Name	o <i>(First, Middle, Mi</i> ne Murray		18)	
I Z	nd Me mark matk	ဥ	19a. Informant's Name/Relationship		19b. Mail	ing Address (Street	and Number or Rura			State. Zip (	Code)
, Ma	27 Is		Patrick Cunning		117		Blvd. Bel				
ore,	item otha		20a. Method of Disposition		20b. Place of Disp				Oc. Location -		
imo	nent of I ant: If ite ury or of		1  Burial 2  Cremation 3 `4  Opnation 5 Other (Speci	_Hemoval from State	_ :	m Cemeter		0/05	Marric	ttsvi	.11e, MD
<b>Balt</b>	Department of Health and Men Important: If item 27 is marke any injury or othar traumatic once.		21. Signature of Funeral Service Lice	ensee	2	2. Name and Addre	ss of Facility Mil	ler-Dipp	el Fun	era1	Home Inc.
ша	.O 5 8 0		JON (NAM	<del>}</del>	16	415 Belai	ir Road Ba	ltimore,	Maryı	aryland 21206	
	nysician	1	23a. Part1. Inter file disease, or con shock, it heart failure. List only immediate Cause (Final disease or condition resulting in death)	y one cause on each line	Rustine.	10.0	loto as cardiac o				Approximate Interval Between winset, and Death
	Medical xaminer			Due to (or as a o	cons +cuence of);	W-12-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1		0			67-1272-2016 P
pelu	d ansit	Examiner	Sequentially list conditions from the sequential year of the sequential seque		consequence of):						
8760, ate be executed	e &	cai	resulting in death) Last	Due to (or as a o	consequence of):						
Division of Vital Records, P.O. Box 68 othe Hospital or Attending Physician: The law requires that the death certifica	he attending   led for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	□Ectopic pregnanc	/		23d. Dai Mo	te of deliver	y Day Year
ds, P.C	signed by the d be detached	by	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	1/		e cause of death?
SOL	been si should	etec	(012					24a. Was an			
al Re	certificate has rector, page 2	Completed						autopsy performu	<b>X</b> vo 1	orior to com death?	sy findings available pletion of cause of
Vit	certif	o Be	25. Was case referred to medical examiner?	Hospital:	2 ER/Outpatie	-t 20 pos Ott	26. Place of Death		1	(0	Son's Rome
o y	er this		27. Manner of Seath	28a. Date of Injury (Month, Day Y		HIL 3 DOA	4   Nursing Ho	me 5 Residen 28d. Describe how			AUTI TIONE
ivision or Attending	within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	XNatural 5 Pending investigation 3 Suicide 6 Could not 4 Homicide determined	be an Bloom of laws	r - At home, farm, si	M 1 🗆	Yes 2□No	28f. Location (Stre City or Town,	et and Numb State)	er or Rural	Route Number,
Hospital o	within 24 hours at To the Funeral D completely filled i	Medical Ce	29a. Certifier 1 artifyin 1 P (Check only one)	Physician: To the best of eminer: On the basis of eminer state	xamination and/or ii	th congress at the free envestigation, in my c	me data and place i pinion, death occurr	and due to the rau ed at the time, dat	sa(s) and ma e and place, a	inner as sta and due to t	ited the cause(s)
o g	To the	Me	29b. Signature and title of certifier	1.		29c. Ligens	e number	290	d. Date signed	Month, D	Pay, Year)
	V		* Kaurene	e Shely to l	+	01.	2809		4/	27/0.	5
	107		30. N. e and address of person who	complete that a clidea	th (Item 23a) (Type	, Print)	1 40	2	for a	1	
	1,	Ш	Landa filly JT.	(1) Good	Samarita	n Hospital	Shot Local	Raven Bl	rd, Ba	ltime	re, Marylan
	Sta Registr		31. Date filed (Month, Day, Year)  APR 9	32. Registrar	s Signature	Coules	/			مک	1239

			For State Registrar	State of Ma	aryland /	-	artment of			-	gien Reg. N	2000	11.500
	O		Decedent's Name (First, Middle, Last)							2. Date of De		0 17	3. Time of Death
	Physici /Medio		Virginia Woodar		У					April	27,	2005	5:00A M
	Examir	er	4a. Facility Name (If not institution, give s	,	1+a1		4b. City, Town	n, or Local Ville		h	40	County of Deat	
	Funeral		Shady Grove Adven  5. Social Security Number  6. Sep		ILAI e (In yrs. last bi	rthday)	If Under 1 Ye	ar If Ur	nder 24 Hrs	8. Date of Bir	th	Montgom 9. Birt	hplace (State or Foreign
	Director		223-16-4271	M 2∭ F	86	Yrs.	Months Da	ys Ho	urs Min.	(Month, Da April	y, Year 2 <b>,</b>	)   Co	ginia
	pu >		Usual Residence of Decedent  10a, State 10b, County		10c. City, Tov	or Lo	antion						10d. Inside City Limits
	Aaryla shor	5			_		Callon						1 ☐ Yes 2 No
	28a-	Director	Maryland Montgome  10e. Street and Number	ĽУ	Poton	iac	10f. Zip Cod	le			10a. C	itizen of What Co	untry?
	3e or		1386 Kimblewick R	oad			208	54			IIn	ited Sta	tes
Maryland 21215-0036	d within 72 hours after death with the Maryland Jione. Ir than "neturel", or Items 23e or 28a-f show The Madical Evertirel must be nullied at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Decedent of Yes, specify C		ic Origin? (S xican, Puer ecify:	pecify Yes or No to Rican, etc.)		14. Race - Ame Black, White Specify:	rican Indian,
2-0	72 ho	ted	15. Decedent's Edu (Specify only highest grade	cation	16a		dent's Usual Oc kind of work do		most of wo	rking		Kind of Business/	Industry
21	ithin nan "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT use re	tired)		ning .	Nat		nstitutes
72	iled tygi ther nt.		17. Father's Name (First, Middle, Last)			upe	rvisor	18 A	Jother's Nar	ne (First, Middle,	Maide	of He	alth
and	ed fall be	To Be	David Dixon Plast	er						Lewis	7712700	Jamamey	
ary	s 1 and 2 should be f Health and Mental H tem 27 Is marked of other traumatic eve	1	19a. Informant's Name/Relationship (Ty		19	b. Mailir	ng Address (Str				er, City	or Town, State, Z	Zip Code)
	5 등 Z 로		Linda Ann Woodard	/Daughter					Road,	Potoma	c, N	laryland	20854
Baltimore,	V		20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ R	emoval from State	cemete	ery, crer	sition (Name of natory or other	place)	May	Bate 2	20c. L	ocation - City or	Town, State
Ë	. Pages tment of I tant: If it jury or o		' 4 ☐ Donation 5 ☐ Other (Specify)		Gate	eme	Heaven tery		2005		Sil	ver Spri	Lng, MD
Bal	permit. Page Department of Important: If eny Injury or once.		21. Signature of Funeral Service Lio		м00803	B B	. Name and Ad ethesda ethesda	dress of F -Chev , Man	vy Charyland	ise Inc	350	7557 Wis	ineral Home/ consin Avenu
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused ne cause on each lin	10.		er the mode of		h as cardia	or respiratory a	rrest,		Approximate Interval Between Onset and Death  CC 45
	/Medical		resulting in death)		a consequence	_							449
	Examiner		Sequentially list conditions,			-0.							
	pe list	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as t	a consequents	Ol):							
	and and al-trar	xan	that initiated events resulting in death) Last	Due to (or as a	a consequence	of):							
8760,	cate be executed bhysician and the burial-transit	dical		l								ĺ	
9		Medi	JE ESMALE.										
O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ☑No 9 ☐ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deat		Ectopic pregna Other (specify					23d. Date of deli Month	very Day Year
٥	that the	by Ph	Part II. Other significant conditions con	tributing to death bu	ut not resulting	in the u	nderlying cause	given in F	Part I.	23e. Did to	obacco	use contribute to	the cause of death?
rds	quires on sign	q pe								10	res 2	No 3□ Pro	obably 4 Unknown
Records,	The law requir ate has been si page 2 should	ompleted								24a. Was autor perfo		death?	topsy findings available completion of cause of
Vital		Be C	25. Was case referred to medical					26. F	Place of Dea	ath (Check only o		12.165	2,0110
of V	Physicien: this certific ral director,	Tof	examiner? 1 Yes 2 No	lospital:		utpatien	t 3 DOA	Other: 4[	Nursing H	lome 5 Resid	dence	6 ☐Other (Spec	sify)
ion	Attending P death. ctor: After t y the funera	atlon:	27. Manner of Death  Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b. (Year)	Time of Injury	1 1	njury at Work? I □ Yes	2 🗆 No	28d. Describe	now inju	iry occurred	
Division	el or Attend s after death Il Director: ,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, f c. (Specify)	arm, str	eet, factory, offi	Ce		28f. Location (S City or Tox			ral Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer.	Medical (	29a. Certifier (Check only one) 2 Medical Exemi	sician: To the best of ner: On the basis of and manner sta	examination a	e, death	n occurred at the	e time, dat ny opinion,	te and place , death occu	, and due to the irred at the time,	cause(s date an	s) and manner as d place, and due	stated. to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	11.7	· m	.0	1	ense num				ate signed (Month	
)	<b>4</b>		Alicia J.	Juisin	T	_	109	597	58		HP	ril Li	7,2005
	10		30. Name and address of person who co	try 90	101 M	edi	cal Con	ater	Driv	e Roc	kvii	lle, MD	20850
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 9 200	5 Registra	ar's Signature	for	de						

			For	State of M		d / Depa	artment	of H	ealth a		ental Hyg			1 1 2-	ا سر -
			- State Registrar			Cei	tificate	OT L	<i>Jeath</i>		2. Date of Dea	eg. No	JUJ	1 Time of	164
	Physicia		Decedent's Name (First, Middle, La							i	Month	Day	2005	3. Time of	Рм
	/Medic	al		anmer	-1		4h Cib. T		Location o		April	26,	∠UUD inty of Death	7:54	
	Examin	er	4a. Facility Name (If not institution, given Anne Arundel Med.)				Anna			n Dealin			ne Arur	dol.	
			5. Social Security Number 6. S			last birthday)	If Under 1		If Under a	24 Hrs.	8. Date of Birth				r Foreign
	Funeral Director		510-38-6886	M 2□F	66	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day) JAN 8 ,	Year) 1939	Kans	lace (State o	
			Usual Residence of Decedent												
	how		10a. State 10b. County			y, Town or Lo	cation						1	0d. Inside Cit	
	B-f.s	cto	TX Harris		Kir	ngwood								1X Yes	2 LI NO
	or 28	Director	10e. Street and Number				10f. Zip (				1		of What Cour	itry?	
	23a	Ta	2514 Brookdale D			- (		7339			M M M	USA	A	lada	
	tems	Funeral	11. Marital Status	12. Was Deceder Armed Forces	5?	.S.   13. \	Was Decede If Yes, speci	ent of His fy Cubar	spanic Orig n, Mexican	gin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)		Race - Americ Black, White,		
36	', or l	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 If Yes, Give Year or Dates	7. 7.140		1 ☐ Yes 2	X No	Specify:			Spe	ocify: Cauc	asian	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. Itan "natural", or Items 23a or 28a-f show tra Medical Ezaminer maist be notified at		15. Decedent's E		-	16a. Dece	dent's Usual	Occupa	ition			16b. Kind o	f Business/In	dustry	
<u></u>	in 72 n "ne Medit	plet	(Specify only highest gr Elementary/Secondary (0-12)	a de completed)  College (1-4o	r 5+)	lite.	kind of work DO NOT use	k done d e retired)	<i>uring</i> mosi )	t of workin					
2	d with	Completed	12	4		Pi	ilot				A	Airlir	e Trar	sporta	ation
b	be filed ital Hygid of other event, I	Bec	17. Father's Name (First, Middle, Las.	")					18. Mothe	er's Name	(First, Middle,	Maiden Sun	name)		
<u>Ja</u>	should band Ments s markad umatic e	10	Lester Cranmer							ie He					
an	2 sho and ls ma		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	ind Numbe	er or Rurai	Route Number	r, City or To	wn, State, Zip	Code)	
	and ealth m 27		Carol (Durgom) C	ranmer -					Driv		ingwood			339	
Ore	Pages 1 nent of H ent: If Itel ary or otl		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 [	Removal from Sta	e c	Place of Dispo semetery, crea	natory or oth	her place			2005		on - City or To		
Ë	tent:		* 4 ☐ Donation 5 ☐ Other (Spec	fy)	Bro	okside			4	5/3/2			n, Tex		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Hyportent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show importent: If Item 27 is marked other than "natural", or Items 1. Items 1		21. Signature of Funeral Service Lice	tulon	an	- 72	50 Was	shin	gton	Blvd	ral Hom	idge,	dowric MD 2	ge MP, 1075	Inc.
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caus	ed the deat line.	h. Do not ent	er the mode	of dying	g, such as	cardiac or	r respiratory arr	est,		Approximate Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition	. Pul	mon	ary	F	100	100	150	~			Onset and [	Jean
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):				-					
	Examine	L	Sequentially list conditions,	b. Due to /or											
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	D09 t0 (01 a	as a conseq	derice or).									
	be executed iclen and burial-transit	xan	that initiated events resulting in death) Last	c Due to (or a	as a conseq	uence of):									
760,	that the death certificate be executed ed by the attending physiclen and detached for use as the burial-transit	calE		d											
687	fficate g phys			u											
Вох	death certifica e attending phi of for use as th	S	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			∃Ectopic pre					23d.	Date of delive	•	
	death e atte	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant	at time of c		Other (spe						Month	Day 1	Year
P.0	that the ed by th detache	Physician/Med	9 Unknown	9 O O O O O O O O O O O O O O O O O O O											
	res tha igned be det	by	Part II. Dther significant conditions	contributing to death	but not res	sulting in the u	inderlying ca	ause give	en in Part I			1	contribute to t		
Records	The law requires ite has been sign age 2 should be										1 U Y	es spon	0 3 L F100	ably 4 🗆 t	JIKIIOWII
ecc	e law r has be ge 2 sh	Completed									24a. Was a autop:	sy	4b. Were auto prior to co death?	psy findings mpletion of c	available ause of
<u>=</u>	The l	Con									perfor	22No	1 Yes	2 No	
Vital	ding Physician: Th th. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	200		(Check only or				
of	Phys r this ral di	: To	1 des 2 No 27. Manner of Death	28a. Date of li		ER/Outpatie		Bc. Injury Work	4 🗆 Nt		ne 5 Resid			V)	
	ding h. After fune	tlon	1 Natural 5 Pending 2 Accident investigate	(Month,	Day Year)	Injury	М		k? Yes 2□						
Division	Attending r death. actor: Afte by the fune	flca	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of	Injury - At h	ome, farm, st	reet, factory,	, office		2	28f. Location (S		umber or Run	I Route Num	iber,
ă	at or a safter	Certification:	4 Homicide	building,	etc. (Specia	<i>TY)</i>					City or Tow	n, Siale)			
	t hours t hours unere	ledical (	(Check only 2 Medical Ext	hysicien: To the be	st of my kno	owledge, deat ation and/or in	h occurred a	at the tim	ne, date an pinion, dea	nd place, a ath occurre	and due to the o	ause(s) and late and pla	d manner as s ce, and due to	tated. the cause(s	i)
	To the Hospital or Attandi within 24 hours after death. To the Funerel Diractor; A completely filled in by the fu	Medi	29b. Signature and title of	and manner	stated.		29c.	. License	e number		2	29d. Date si	gned (Monty),	Day, Year)	
	¥ ¥ 5 8		1	1/	M	0	0	1	(1	S -	7	/	26/0		
,	18	V	30. Name and address of person him	completed cause of	of death (Ite	m 23a) (Tvna	Print	. د ر	7/1	<u> </u>		1 1	20/0	<u></u>	1
	151		Aimee	10			An	ne	H	v - ~ ~	121	Mad	Leal	10.00	tor
		ate	31. Date filed (Month, Day, Year)	32. Reg	strar's Sign	ature	AP a				-		1		
	Regist	rar	APR 2 9 2005	A Des	O Make	The state of the s	Ros								

DHMH 17 Rev 1/2001

			_ FOI	nd / Department of		ntal Hygien	9005	11,565
			State Registrar	Certificate of		Reg. N	.o.	19000
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	Dalton	/-	April 2	1 2005	3. Time of Death
	Examin	er	pairimore Renabili	ktended 4b. City, Town	timore	4	c. County of Death N/A	
	Funeral		Care Center  5. Social Security Number  6. Sex  7. Age (In yrs.	last birthday) If Under 1 Ye	ear If Under 24 Hrs. 8	Date of Birth (Month, Day, Year	r) 9. Birthi	place (State or Foreign
	Director		250-14-8627 Usual Residence of Decedent	86 Yrs.		MAY 11 19	18 SOUT	H CAROLINA
	aryland show	Ļ	10a. State 10b. County 10c. Ci	ity, Town or Location				10d. Inside City Limits 1 XXes 2 □ No
	the Ma	ecto	MARYLAND N/A B.  10e. Street and Number	ALTIMORE 10f. Zip Cod	le	10g. C	citizen of What Cou	
	h with	Funeral Director	2729 BOOKERT DR.		215	109.0	U.S.A.	,
	r deat	ner	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was Decedent	of Hispanic Origin? (Speci Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ameri Black, White,	
39	within 72 hours after death with the Maryland ane. then 'natural', or Iteme 23e or 28a-f show the Medical Exercites mast be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 41/	1 ☐ Yes 2 🔀 I	No Specify:		Specify: BLAC	K
21215-0036	72 hou	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Oc (Give kind of work do	ne during most of working	16b.	Kind of Business/In	
121	within ene. then "	Completed	Elementary/Secondary (0·12) College (1·4or 5+)	life. DO NOT use re	tired)	9	SOCIAL SE	CURTTY
	be filed tal Hygi d other event, I	Be Co	12 yrs 2 yrs 17. Father's Name (First, Middle, Last)	AUDITER	18. Mother's Name (			
ylaı	2 should be to and Mental the is marked ore	To	unknown		unknown			2
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar f Health and Mental Hyglene f Health and Mental Hyglene filem 27 is marked other then "natural", or fleme 23e or 28a-f show other treumatic event, the McJical Evacular must be notified at		19a. Informant's Name/Relationship (Type, Print)  Shiela Dalton/Daughter	19b. Mailing Address (Str.	eet and Number or Hural I rt Dr., Balt		140	
	of Health of Health if item 27 i		20a Method of Disposition 20b. I	Place of Disposition (Name of cemetery, crematory or other	Dat		Location - City or T	
Baltimore,	. Page tment tent: It		'4 □Donation 5 □Other (Specify) CR	OWNSVILLE VET		-05 CRC	WNSVILLE	, MARYLAND
Bal	permit. Pages 'Department of H Importent: If ite any injury or ot once.		21. Signal of of Funeral Service Licent		dress of Facility C BROWN COMM ORTH AVENUE	UNITY FUN	ERAL HOM	E P.A.
			296. Part1. Enter the disease, or complications that caused the dear shock, or heart failure. List only one cause on each line.	th. Do not enter the mode of	dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a		-nTIa			
	Examiner		Supertially list conditions b. Stroke	1/1				
٧	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence of):				
oʻ	ate be executed hysicien and the burial-transit		that initiated events c.  Due to (or as a consecuting in death) Last	quence of):				
8760,	@ <u>_</u>	dicai	d					
9 xo	nding use as	n/Me	IF FEMALE: 23c. If yes, outcome of pregnant				23d. Date of deliv	ery
О. В		Physician/Med	1				Month	Day Year
S, P.		by Ph	Part II. Other significant conditions contributing to death but not rec	sulting in the underlying cause	given in Part I.	23e. Did tobacco	use contribute to t	he cause of death?
ecords	The law requires are has been sign bage 2 should be	ted k	Urinary Iract Infection	on		1 ☐ Yes	2 No 3 Prol	bably 4 □Unknown
Rec	has by	Completed	Diabetis Mellitus			24a. Was an autopsy performed?	24b. Were auto prior to co death?	opsy findings available impletion of cause of
Vital		Be Co	HVDentenSION 25. We asserted to medi		26. Place of Death (	1 ☐ Yes 2 N Check only one)	lo 1 Yes	2 No
of Vi	ys dis	To B		ER/Outpatient 3 DOA	Other: 4 Ursing Home	5 Residence	6 □Other (Speci	fy)
o uc	Jing After fune	tion:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation		njury at 28 Work? 1 □ Yes 2 □ No	d. Describe how inj	ury occurred	
Division	or Attendition of Att	Certification;	2 Suiside 6 Could not be	nome, farm, street, factory, offi		f. Location (Street a City or Town, Sta		al Route Number,
U	Hoepite 4 hours Funerei ely fillec	edicai Ce	29a. Certifier (Check only   Medical Examiner: On the basis of examiner)					
	To the within 2 To the complet	Med	one) and manner stated.  29b. Signature and title of certifier	29c. Lic	ensa number	29d. D	ate signed (Month,	Day, Year)
	. ,		) <u>/</u>	05	6508	a	pril 2	7505
			30. Name and address of person who completed cause of death (tell	m 23a) (Type, Print) 390	o Loch Ro timore	Iven Bo	ulevar	d
ľ	Sta Registr	_	31. Date filed (Vonth, Day, Year) 32. Pustrar's Sign.	ature Aserti	,			

				For State of Maryland / Department		and Mental Hy	giene 115	14566
				State Registramend item #1&6 PER phy&fh g842 14 12 15	POST UTBATH	2. Date of De	Reg. No.	3. Time of Death
_		Physicia		<del>CLAYTON DAVIS</del> CLAYTEAN DAVIS		04·26	· 2005	
		/Medic Examin		a. Facility Name (If not institution, give street and number)  4b. City,	Town, or Location of		4c. County of De	
				5002 LINDSAY ROAD  Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	TMORE  1 Year   If Under	24 Hrs.   R Date of Bir		A Listhplace (State or Foreign
		uneral irector		212 · 40 · 0355 Months 4	Days Hours	24 Hrs. 8. Date of Bir (Month, Da	19. Year)	Birthplace (State or Foreign Country)
	pu	2	-	Jsual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryla	sho	ō	MD NA BALTIMORE				1 K Yes 2 □ No
	the the	r 28a	irec	0e. Street and Number 10f. Zip	Code		10g. Citizen of What	Country?
	ath wit	238 c	raiD	5002 LINDSAY ROAD	21229		us	
	ler de	ltems Intern	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 18 No	dent of Hispanic Ori orly Cuban, Mexicar	gin? (Specify Yes or No n, Puerto Rican, etc.)	0- 14. Race - Ar Black, W	nerican Indian, hite, etc.
	036 ours af	Exam	by	If Yes, Give 1 ☐ Yes 3	2 ₺No Specify:		Specify:	SLACK
	<b>5-0</b>	dical	eted	15. Decedent's Education 16a. Decedent's Usua (Specify only highest grade completed) (Give kind of wo	rk done durina mos	t of working	16b. Kind of Busine	ss/Industry
	d 21215-0036 filled within 72 hours after death with the Maryland	than the Mg	Completed	Elementary/Secondary (0-12)  College (1-4or 5+)  NA  HOME MA	KER		DOMESTIC	
	beliled to the	na wentar hygiene marked other tha matic event, the	BeC	17. Father's Name (First, Middle, Last)		er's Name (First, Middle	a, Maiden Surname)	
	Maryland	werked natice	Tof	OWEN DAVIS	ETHE	EL JONES		
	<b>0</b>	E 00 5		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address 5002 110	(Street and Number	er or Rural Route Numb  D. BALTO-		a, Zip Code) I <b>ว ว</b> นี
	ore, N	item 27 l		20a. Method of Disposition 20b. Place of Disposition (Nar	me of other place)	Date	20c. Location - City	or Town, State
	Baltimore,	ant: If		*4 Donation 5 Other (Specify)	RK C	4.30.05	BALTO. MC	)
	Balt permit.	Department of the function of		21. Signatore of Funeral Service Licensee VAUGHN	O - GREEN	JE FUNERAL PIKE, BALTO	SERVICE	79
				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mod shock, or head allure. List only one cause on each line.	le of dying, such as	cardiac or respiratory a	arrest,	Approximate Interval Between
		ysician	2 6	Immediate Cause (Final disease or condition Mataria Cervical C				Onset and Death  Months
,		ledical aminer		Due to (or as a consequence of):				> marths
12			ner	Sequentially list conditions, Tary, leading to introducte cause. Either Underlying				111011 11/23
2005	ecuted	and transi	Examiner	Cause (Disease or injury that initiated events c.				
9	68760, ficate be executed	sician and burial-transit		Due to (or as a consequence of):				
7	687 tificate	the state of	ledical	d.				
April	Box	attending i	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 mg m/hs?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pi			23d. Date of Month	delive <b>ry</b> Day Year
X	O. F	the a	ysici	1   Yes 2 1   No 9   Unknown   Unknown   Unknown   1   Yes 2   1	pecify)			24,
5	I Records, P.O. Box 6 The law requires that the death certif	been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying of	cause given in Part I	. 23e. Did	tobacco use contribute	to the cause of death?
1:58pm	ords equire	en sig ould b				1 🗆	Yes 2□No 3□	Probably 4 Donknown
15	Records,	2 2	Completed			24a. Was	s an 24b. Were prior death	autopsy findings available to completion of cause of
welliep		is certificate ha director, page	e Co	25. Was case referred to medical	26 Bloo		2 <b>12</b> No 1□Y	
K.	of Vita	is cert direct	O B	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DC		ursing Home 5 Hes		pecify)
Da		After thi funeral	ou:		28c. Injury at Work?	28d. Describe	how injury occurred	
2	Division or Attending	death ctor: A y the fi	ficat	2 Accident investigation M 3 Suicide 6 Could not be determined 28e. Place of Injury: At home, Jarm, street, factor	1 ☐ Yes 2 ☐		(Street and Number or	Rural Route Number,
laytean Davis	Div	s after	Certification;	4 Homicide determined building, etc. (Specify)	,,		iwn, State)	
78	To the Hospital	within 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred and manner stated.	at the time, date ar n, in my opinion, dea	nd place, and due to the ath occurred at the time	e cause(s) and manner o, date and place, and o	as stated. due to the cause(s)
	Toth	within To th compl	Me	29b. Signature and title of certifier 29	c. License number		29d. Date signed (M	
	$\prec$			► 2/80 MD	D2417	U	April 27	,2005
	3	<u>-</u> 289		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Tso MD Richey Hospice 838 N Eutan	V St Bo	o eltimore Y	10 2120	
		Sta Regist		31. Date filed (Month, Day, Year) 932. Registrar's Signature APR 2 9 2005				

			For State Registrar	State o	f Marylar	-		of Health of Death		-	giene Reg. No.	05	14567
	Physicia		1. Decedent's Name (First, Middle							2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al		Go1d		Deloa				4		2005	5:30 p. M
	Examin	er	4a. Facility Name ( <i>If not institution</i> 2029 Feather	n, give street and nur bed Lane	nber)		Balt	own, or Location	of Death		N/A	ty of Death	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year If Unde	r 24 Hrs.	8. Date of Bir (Month, Da		9. Birth	place (State or Foreign
	Director		242-78-8573	1□M 2 <b>X</b> F	96	Yrs.	Months	Days Hours	Min.	2-2	6-1909	Cou	N.C.
	pu *	-	Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	Maryla f sho	ō	Md	N/		alto							1X Yes 2 □ No
	r 28a-	rect	10e. Street and Number				10f. Zip C	Code			10g. Citizen o	f What Cou	ntry?
	th with	Funeral Director	2029 Featherb	ed Lane				21207			US	A	
	r dea	ner	11. Marital Status	Armed Fo		J.S. 13.	Was Decede	ent of Hispanic O fy Cuban, Mexica	rigin? (Sp	ecify Yes or No Rican, etc.)		ace - Ameri	
36	rs afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes Giv	/8		1□Yes 2l				Spec	ity: B1	ack
21215-0036	d within 72 hours after death with the Maryland piene. Then "natural; or items 23e or 28e-f show The Mackeal Examinational be notified at		15. Deceden	nt's Education			dent's Usual		. ,		16b. Kind of	Business/In	ndustry
215	- 3	Completed	Elementary/Secondary (0-12)	st grade completed) College (1	1-4or 5+)	life.	kind of work DO NOT use	done during mo retired)	st of work	ing	11.0		
2	filed within I Hygiene. other then		8th grade  17. Father's Name (First, Middle,	/ next)	N/A	H	ousewi			- (C: ) 11 day	Home		
lanc	o d to o	To Be	William Tyler	•					rne1	ə (First, Middle, lia Fl	, маідел Sumi .ood	ime)	
Maryland			19a. Informant's Name/Relations Bertrand M. Del		on			Street and Numb					Code)
altimore,	m O	İ	20a. Method of Disposition 1   Burial 2 □ Cremation		State	Place of Dispo	natory or oth	ner place)		Date	20c. Location		
iţi.	permit. Page Department Important: If any injury o		* 4 □ Donation 5 □ Other (S 21. Signature of Fineral Service		1 3			Bapt Ch Address of Faci			Roxbel H West		•
B	Per Pep Imp		Y Xala	Marie	_	4				venue			1215
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that of t only one cause on e	caused the dea each line.	th. Do not en	er the mode	1	-				Approximate Interval Between
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	-a Acu	te n	nyoc	ardio	6/ 11	1+4	rcti	Ohi		Onset and Death
	Examiner		toodang at dodan,	Due to	(or as a consec	quence of):							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a consec	quence oi).			-				
Ò	acuted ind transi	Examln	Cause (Disease or injury that initiated events resulting in death) Last	с.									
8760,	be executed sician and burial-transit		resulting in deathy East	Due to	(or as a consec	quence of):						1	
687	ificate t g physical as the b	edic		d									
ŏ	leath certifici attending pl	M/us	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn		Ectopic pre	anancy			1	ate of deliv	ery
O. B	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medicai	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		nant at time of		Other (spec					Month	Day Year
P.O.	es that the de igned by the a be detached		Part II. Other significant conditi	ons contributing to d	eath but not re	sulting in the u	nderlying cau	use given in Part	1.	23e. Did t	obacco use co	ntribute to t	he cause of death?
Records,	v requires been sign should be	ed by	Diabetes 1	Mc//ITU	<u>ک</u>					10	Yes 2 No	3 🗌 Prot	bably 4 DUnknown
000	e law requ has been je 2 shoult	Completed	Hypertensi	ah						24a. Was		. Were auto	opsy findings available impletion of cause of
<u> </u>		Con	Senile De	monti	ei.						2 No	death?	2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital				Othon		h (Check only o	one)		
of	Phys this ral dii	: To	1 ☐ Yes 2 No 27. Mann of Death	1 1	Inpatient 2 C	ER/Outpaties 28b. Time o		The state of the s	lursing Ho	me 5 esi 28d. Describe l		ther (Specii urred	(y)
on	Attending Phy r death. ector: After this by the funeral o	atlor	1 VNatural 5 ☐ Pendi	ng (Mon igation	of Injury th, Day Year)	Injury	М	c. Injury at Work? 1 Tyes 2	No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Division	i or Attendi after death. Director: A i in by the fu	Certification;	3 Suicide 6 Could 4 Homicide deterr	nined 289. Place	of Injury - At I ing, etc. (Spec	nome, farm, st ify)	reet, factory,	office		28f. Location ( City or Tox	Street and Nur wn, State)	nber or Rura	al Route Number,
	ospite hours inerei y fillec	edical C	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the I Examiner: On the b and man	e best of my kn easis of examin	owledge, deat ation and/or in	h occurred at vestigation, i	t the time, date a in my opinion, de	ind place, eath occur	and due to the red at the time,	cause(s) and r date and place	nanner as s a, and due t	stated. o the cause(s)
	within 24 To the Fu To the Fu completel	Med	29b. Signature and title of certific		_			License number			29d. Date sign		
)					M	2	D.	28231	0	/	April >	-6,2	-005
	- / 1								er'				
	1		30. Name and address of person	who completed cause	se of death (Ite	m 23a) (Type,	Print)	ne RI	1 B	414	mn 2	-/2	-8

Baltimo	
Box 68760,	
P.O. E	
Records,	
Vital	
o	
Division	

							lealth and Mo	-	-	
	•	For State Registrar			•	tificate of l			. Ne. 0 0 5	14568
Physicia	an	Decedent's Name (First, Middle,						Date of Death Month	Day Year	3. Time of Death
/Medic	al	Mary Igleh 4a. Facility Name (If not institution,		nber)		4h City Town o	r Location of Death	APR1L	26 200 4c. County of Dee	
Examin		SINAI HOS			J MO:		BALTIN	OME	N/A	41
Funeral			6. Sex 1 ☐ M 2/Q F	7. Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8 Date of Birth	a Bi	rthplace (State or Foreign ountry)
Director	ļ	219–22–7165 Usuel Residence of Decedent		77	Yrs.			March 28,	1928 Mai	ryland
ryland how		10a. State 10b. County		10c. City, T	own or Lo	cation			,	10d. Inside City Limits
8a-fs	ecto	Maryland N/A		Balt	timore					XX Yes 2 No
with t	Funeral Director	10e. Street and Number 122 East Melrose Av	an ia			10f. Zip Code	1212	109	g. Citizen of What C USA	ountry?
death	nera	11. Marital Status		dent Ever in U.S.	13. \		lispanic Origin? (Specan, Mexican, Puerto F	cify Yes or No-	14. Race - Am	
s after or ite	by Fu	1 Never Married 2 Marrie	1 Tes	2 <b>XX</b> No		1 □ Yes <b>3(0)</b> (No	Specify:	ilicali, etc./	Black, Whi	White
2 hour	ed b	3 Widowed 4 □ Divorced 15. Decedent'.	Year or Da		6a. Deced	ient's Usual Occup	ation	16	6b. Kind of Business	
thin 72 e. an "na Media	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-		(Give	kind of work done of DO NOT use retired	during most of workin	g		,
iled wi Hygien Iher th		17. Father's Name (First, Middle, L	4			Homemak	(er 18. Mother's Name	/Einst Middle Mr	Own Ho	ome
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Items 23e or 28e-f show reumetic event, the Medical Examinat must be redified at	To Be	William Locke Taylo						n Digges	iden sumame)	
shou and M s mar	1	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailin	ng Address (Street	and Number or Rural	Route Number, (	City or Town, State,	Zip Code)
and 2 ealth i		Barry Rollins		POA/EXEC			Towson Mary			
Pages 1 nent of H snt: If Ite sry or otl		20a. Method of Disposition  1  Burial 2  remation		State COMI	etery, cren	sition (Name of natory or other place Cenetery			oc. Location - City of 1timore, Mai	
		Donation 5 ☐ Other (Sp 2 gnature of Funeral Service L		- Julean	-		ss of Facility Mito			
permit. Departr Importe any inj		Dennis Xysk	en Merca	Res					timore, Mar	
		23a. Part1. Enter the disease, or c shock, or heart failure. List of	complications that cannot one cause on e	aused the death. I ach line.	Do not ent	er the mode of dyin	ng, such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		EPTIC		SHC	DCK			Iday
Examiner				or as a consequen	ice of):					0
D =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (	or as a consequen	ice of):					
be executed siclan and burial-translt	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequen	ice of):					
te be ex ysiclan ie buria	cai E		d and							
rtificate ng phy as the	edi	IF CELLAL E.	- U							
The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live bi	come of pregnancy irth 2 Petal de	ath 3	Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
res that the de signed by the a be detached f	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	9☐ Unkno	ant at time of deatl	n 5L	Other (specify)				,
is that gned b	by Pł	Part II. Other significant condition				, ,		1	cco use contribute t	o the cause of death?
w require been sig should b	ted t	Chronic	obsm	uchu	a P	ulmera	ساطنعن	1 ☐ Yes	2 □ No 3 X P	robably 4 Unknown
e law r has be	Completed							24a. Was an autopsy	prior to	utopsy findings available completion of cause of
sicien: The law certificate has t irector, page 2 s	e Co	25. Was case referred to medical						performe 1 ☐ Yes		s 🕰 No
ysicien: is certific director,	O B	examiner?	Hospital:	npatient 2 ER	/Outpatien	at 3 DOA Oth	26. Place of Death er: 4 ☐ Nursing Hom		ce 6 ☐Other (Spe	ecify)
Attending Physicien: r death. sctor: After this certifica by the funeral director, I	on: T	27. Manner of Death  Natural 5 Pending	28a. Date of	of Injury 28 th, Day Year)	Bb. Time of Injury	28c. Injur Wor	y at 2	8d. Describe how		
Attendir death. ctor: Al y the fu	icati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ation ot be	of Injury - At home	tarm etc		Yes 2 No	8f Location (Stre	et and Number or E	lural Route Number,
al or At after o I Direct d in by	Certification:	4  Homicide determi		ng, etc. (Specify)	5, 141111, SU	eet, factory, office		City or Town,	State)	urai noute ivamber,
To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical (	29a. Certifier Certifying	J Physician: To the	best of my knowle	edge, death	occurred at the tir	ne, date and place, a ppinion, death occurre	nd due to the cau	se(s) and manner a	s stated.
To the h within 24 To the f complete	Medi	one) 29b. Signature and title of certifier	and manr	ner stated.		29c. Licens			d. Date signed (Mon	
F X F 8			enco	100	2					
2		30. Name and address of person v	vho completed caus	e of death (Item 23	3a) (Type,	Print)		J /	110210	26,2005
1		Komar La	NASYLE	mp, s	INA	HOSPI	TAR OF	2 CF	LTIMO	Q=
Sta Registr		31. Date filed (Month, Day, Year)	9 2005	Istrar's Signature	K 4	books				

			. For	State of Marylar						-		-		
			1 - Stete Registrar		Ce	rtificate	e of L	Death			Reg. No.	2005	14569	9
	Physici	an	Decedent's Name (First, Middle, Last	r)						2. Date of De Month	ath Day	/ Year	3. Time of Death	4
	/Medic	al	Vera M. Dorn  4a. Facility Name (If not institution, give	etreet and number)		4h City 3	Town or	Location of		APRIL	27	2000 County of Dea		Λ
	Examin	er		see, 900, Caton	Ave	Balt			Di Deam		46.	County of Dea	un	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.		If Under	1 Year	If Under		3. Date of Birt	th	9. Bji	thplace (State or Foreign	חנ
L	Director		219-20-53/3	□M 2ᡚF 78	Yrs.	Months	Days	Hours	Min.	(Month, Da Sept.2	7,19	26 Mar	yland	
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation							10d. Inside City Limits	s
	Maryl f sho	tor	Maryland Baltimor	e Cat	onsvil	10							1 ☐ Yes 2 ☑ No	
	r 28a	irec	10e. Street and Number	000	OHSVII	10f. Zip	Code				10g. Citi	izen of What C	ountry?	
	th with	al D	326 Stratford Roa	d		2	1228				USA			
	ar dea tams	uner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Deced If Yes, spec	ent of Hi ify Cuba	spanic Orig	gin? (Spec	ify Yes or No ican, etc.)	-	14. Race - Am Black, Whi		
36	rs afte	эу F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ <b>X</b> No If Yes, Give Year or Dates:		1□Yes 2	2. No	Specify:					White	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-1 show the Modical Exemirer must be notified at	Completed by Funeral Director	15. Decedent's Ed	ucation	16a. Dece	dent's Usua	l Occupa	ation			16b. Ki	nd of Business	/Industry	_
215	thin 7. B.	ple	(Specify only highest grad Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give	kind of wor DO NOT us	k done d e retired	during most )	t of working	7				
	led wi ygien har th	Con	12		Н	omemal	ker					Own Hom	ie	
and	i be fil ntal H ed otl	Be	17. Father's Name (First, Middle, Last)  John Fick							First, Middle,		Sumame)		
Maryland	should nd Me mark matic	ို	19a. Informant's Name/Relationship (T	vpe, Print)	19b. Maili	na Address	(Street a	-		Bohni		r Town, State,	Zin Code)	_
	nd 2 salth ar 27 is r trau		Norman Dorn	Husband								MD 212	, ,	
J.	ss 1 a of Hea itam		20a. Method of Disposition	20b.	Place of Dispo	osition (Nam	re of		Da	te		cation - City or		
<u>ii</u>	Page ment ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	adowrio				/30/0	5	E1kr	idge, l	Maryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23s or 28s-f show any riqury or other traumatic avent, the Medical Examiner must be notified at ance.		21. Signature of Paneral Service Livens		2	2. Name and Ster	d Addres	s of Facilit	on Sc	hwab I	Tuner	ral Hom	e.Inc.	
	707 e d		23a. Part 1. Enter the disease, or comp	Molz	-70	/30 1	camo	nason	Aver	iue; cat	conv:	ille, M	D 21228	_
			shock, or heart failure. List only o	one cause on each line.	un. Do not en	ter the mode	a or ayını	g, such as	cardiac or	respiratory ai	rrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. Houtic  Due to (or as a consec		dis							X 2yers	
	Examiner			. CHF (	Conger	tive	Hon	at F	silva.	)			X 2	
	B ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence(of):		Cec	70	<del>unio</del>	/			2910	_
/	ecuted and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
,092	te be executed ysician and se burial-transit	cal E	L.	Due to (or as a consec	quence or):									
687	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit		•	d										_
Box	death certifica e attending ph id for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1☐Live birth 2☐Feta		70					2	23d. Date of de	livery	
-	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of a		□Ectopic pre □ Other (spe						Month	Day Year	
P.0	requires that the teen signed by the	Phy	9 ☐ Unknown  Part II. Other significant conditions co		audia a ia ala a			- i- O i		ODD Dida			o the cause of death?	
ds,	signe d be c	d by	Signoid	Dévention		indenying ca	iuse give	en in Part I.	•				robably 4 donknown	n
Records,	law requ as been 2 shoul	lete	Signor	De Office	600173					24a. Was			utopsy findings available	
Re	The lar	omp								autop	rmed?	prior to death?	completion of cause of	3
Vital	lan: Trifical	Be C	25. Was case referred to medical					26. Place	of Death (	1 ☐ Yes Check only o		1 L Yes	3 2 □ No	
of V	hysic his ce	ToE	examiner? 1 \( \text{Yes} \) 2 \( \text{No} \)	V .	] ER/Outpatie	nt 3 DO	A Othe	ar: 4 🗆 Nu	rsing Home	5 ☐ Resid	dence 6	3 □Other (Spe	ocify)	
n C	ing P		27. Manner of Death  1. ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		Bc. Injury Work			d. Describe h	now injur	y occurred		
Division	Attending or death. actor: After by the funer	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome form at	M Contract		Yes 2□N		f Location /6	Stmat on	d Number of D	ural Route Number.	
Οį	after after Dirac	Certification:	4 Homicide determined	building, etc. (Speci	ify)	reet, raciory,	, once		20	City or Tou	vn, State,	)	urar noute reumber,	
	To the Hospital or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	alc	29a. Certifier Certifying Phy	sicien: To the best of my kn	owledge, deat	h occurred a	at the tim	e, date and	d place, an	d due to the	cause(s)	and manner as	s stated.	
	tha Ho sin 24 tha Fu spletel	ledical	0110)	iner: On the basis of examination and manner stated.	ation and/or in	ivestigation,	in my op	oinion, deat	th occurred	at the time,	date and	place, and due	e to the cause(s)	
	To To con	Σ	29b. Signature and title of certifier  Out- Suither	Valla		29c.	License	number مر	0			e signed (Mont		
	4					1		759	9		4/	27/05		
	9		30. Name and address of person who of	P Clan D	m 23a) (Type, tou Ave	Print) B	thi	Man.	M	10-2	12:	29		
	Sta	ite	St-Hgus Health ( 31. Date filed (Month, Day, Year) APR	32. Registrar Sign	ature	1 60	whi	,	/		- 0			
	Regist	ar	APR	2 9 2040 1000	William Ju	1								

DORN, VERA

		State of Maryland /	Department of Health and Mental F  Certificate of Death	lygiene
Physic		1. Decedent's Name (First, Middle, Last)  Mary Delores Drake	2. Date of Month April	Day Yeer
/Medi Examii		4a. Facility Name (If not institution, give street and number) 1532 Poplar Grove St.	4b. City, Town, or Location of Death  Baltimore	22, 2005 6:30 p M 4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last 7. 4	birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min (Month)	Day, Year) Country)
Maryland -I show	tor		own or Location	10d. Inside City Limits  X☐Yes 2☐No
h with the	Funeral Director	10e. Street and Number 1532 Poplar Grove St.	10f. Zip Code 21216	10g. Citizen of What Country?
be filed within 72 hours after death with the Maryland hall Hygiene. Idea the than "natural", or tiems 23a or 28a-1 show event, the Medicul Exart in at most be redified at	þ	11. Marital Status  1 Never Married 2 Married  1 Never Married 3 Married  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 3 Married  1 Never Married 3 Married  1 Never Married 4 Never Married 4 Married  1 Never Married 4 Never Married	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☑ No Specify:	
Inial yiallid Z.I.Z.I.Z.D.D.D.D.D.D.D.D.D.D.D.D.D.D.D.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)  Louis Stephenson	omestic  18. Mother's Name (First, Middle Mary Nickens	
	To	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or Rural Route Nur 532 Poplar Grove St. Ba	nber, City or Town, State, Zip Code)
Dallinore, IVI permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra pnce.		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place ceme	of Disposition (Name of otery, crematory or other place)  ed Heart 4-27-05	20c. Location - City or Town, State  Dundalk MD
permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Wesley 2007 Eastern Ave. Ba	Chavis Jr. FH. lto. MD 21231
Find / Medical Examiner per partial transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last  Due to (or as a consequence of Consequence of	ce of):	y arrest, Approximate Interval Between Onset and Death
the attending phicked for use as it	Physician/Medic	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death		23d. Date of delivery Month Day Year
w requires that the bear signed by should be detact	by	Part II. Other significant conditions contributing to death but not resulting		d tobacco use contribute to the cause of death?
The law ate has b page 2 si	Completed		24a. W au pe 1   7x	topsy prior to completion of cause of death?
ding Physician: The After this certification of the control of the	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/0  27. Manner of Death 1-Natural 5 Pending (Month, Day Year) 2 Accident investigation		y one) esidence 6 Other (Specify) e how injury occurred
To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: Atter this completely filled in by the funeral director.	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office 28f. Location	n (Street and Number or Rural Route Number, Town, State)
To the Hospital within 24 hours a To the Funeral C	Medical (	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	fge, death occurred at the time, date and place, and due to the and/or investigation, in my opinion, death occurred at the time	e, date and place, and due to the cause(s)
To with	2	29b. Signature and title of certifier  Pan Powerland, with	29c. License number	29d. Date signed (Month, Day, Year)  Apr. (26, 2005
St	te	30. Name and address of person who completed cause of death (Item 23a	Buttimore, Ma 2020	15-
Regist		APR 2 9 2005	Agoria .	

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 April 25, **Physician** Calvin O'Neil Dash 2:17 PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1⊠M 2□F New York Director 075-18-9241 80 Yrs. Nov. 6, 1924 Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23e or 28e-f show the Medical Exercit refirms the notified at 1 ☐Yes 21 No Director Silver Spring Marvland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2608 Baywood Court United States 20906 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: WW II 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☒ No <sup>Specity:</sup> Airican-American þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then College (1-4or 5+) Elementary/Secondary (0-12) Singer/Professor Music Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 should be riment of Health and Mental " ant: If item 27 is " ould be f Mental I Willis Dash Sylvia Cumberbatch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Dash/Wife 2608 Baywood Court, Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other plac Parklawn Memorial Park April 29, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit, Page Department o Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 300 West Montgomery Ave., Rockville, MD 20850-2805 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mitral Valve Injury **Physician** /Medical Due to (or as a consequence of): **Examiner** Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter ornoenying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed Due to (or as a consequence of) physician a Physician/Medical nding pl IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ign be Questionable Ischemic Bowel 1 ☐ Yes 2 ☐ No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2□ No 1 Yes 2 X No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1X Yes 2 □ No 1 X Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 T Homicide within 24 hours a To the Funerel [ 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of ceptifier 29c. License number 29d. Date signed (Month, Day, Year) MD 61623 4 April 26, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

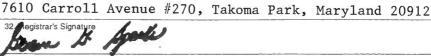
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year)

Cynthia Plate, M.D.

APR 2 9 2005



State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:20 AM<sup>M</sup> April Carol Ann Doyle 25, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Director 1954 213-66-2018 50 May 11, Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23e 17129 Redland Road 20855 <u>United States</u> Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced White "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Director Food Service 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Joseph McCormick Corrinne Ruth Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 is n eny injury or other treun once. Sean Doyle/ Husband 17129 Redland Road Derwood, Maryland 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium Inc. April 28, 2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final clea Brain Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Anoxic ence Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed arre estiva 01 Due to (or as a consequence of): 1)e re men-Physician/Medical lirium IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant, 3 Ectopic pregnancy in the past 12 months Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Alcoho abute 1 ☐ Yes 2 ☐ H6 3 ☐ Probably 4 ☐ Unknown director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 1□ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To filled in by the funeral 28b. Time of 28c. Injury at Work? 27. Manner 28d. Describe how injury occurred After 1 Hospitel or Attending 1 Tural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 🕦 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 04/25 2005 MD 00054068 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LSESE I E HERT(G M) -Shady a rove Hospital-Nochville

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 9 2005

32 Registrar's Signature

		For State Registrar	State of Maryland		cate of De			leg. No.	105	1457
		1. Decedent's Name (First, Middle, Las					2. Date of Dea Month		Year	3. Time of Deat
hysici /Medic		Eugene V	Varren Edwar	ds			April	22, 20	005	8:30PA
Examin		4a. Facility Name (If not institution, give	street and number)	4b.	City, Town, or Lo	cation of Death		4c. Cou	nty of Death	
		Washington Adve	entist Hospital	- !	Takoma I	Park		Mont	gomer	У
ıneral		Social Security Number     6. Security Number	711 005	Mor		Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	9. Birth	place (State or For
rector		770 40 7172	<sup>2□ F</sup> 62	Yrs.	iiis bays i	IVIIII.	8. Date of Birtl (Month, Day July 8,	1942	Wis	consin
> =		Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Location						104 (44)
sho i	-									10d. Inside City Lin 1 ☐ Yes 2√
8a-1	ecto	Maryland Prince Ge	eorge's		estville	5				
Per De	Funeral Director	10e. Street and Number		10	f. Zip Code			10g. Citizen		ntry?
8 234 H	rai	2704 Ritchie Road			20747				5.A.	
ltem Der	n	11. Maritaf Status	12. Was Decedent Ever in U.S Amed Forces?	If Yes,	Decedent of Hispa , specify Cuban, N	anic Origin? (Spe Mexican, Puerto F	city Yes or No- Rican, etc.)	14. F	Race - Ameri Black, White,	
o 🗒	γF	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐Yes 2 ☐ No 1960 If Yes, Give Year or Dates: 1966	1 O Y	es 25√No S	Specify:		Spe	cify: Wh	ite
tural RES	Completed by		1,00		Houst Convention			10h Kind of		
adia official	jet	15. Decedent's Ed (Specify only highest grad	de completed)	16a. Decedent's (Give kind of life, DO NO	of work done duri OT use retired)	ng most of workir	g	16b. Kind of	business/ir	laustry
7 is marked other than " traumatic event, I've Mex	E C	Elementary/Secondary (0-12)	College (1-4or 5+)	P1umbe				Const	ructi	n.n
the nt. 1	Ö	17. Father's Name (First, Middle, Last)		Tambe		. Mother's Name	(First Middle			311
9 A 6	Be		Edwards				de Vivi		/	
nation	2	19a. Informant's Name/Relationship (7		405 Mailles Ada	d (Ct					0.41
7 Is r		Tina Edwards (Day	,, ,	19b. Mailing Add						
ther		20a. Method of Disposition	<del>-</del>		tchie Ro		-			
Important: If tiem 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event. Ite Medical Examinar must be notified at once.		1 Murial 2 Cremation 3	nestioval itolii State	ace of Disposition metery, crematory		May &	,	20c. Locatio	n - City or 1	own, State
Important: If any injury or once.		`4 □Donation 5 □ Other (Specify		yland Ve	terans (	Cem. 200	5	Che1te	nham.	Marylan
ny in		21. Signature of Funeral Service Licen.	500		ne and Address o				,	
트륨레		neuto Do	LYLY) moize	4 6633	01d A1e	exandria	Ferry	Road C	linto	n, MD 20
- 1		23a. Part1. Enter the disease, or comp	lications that caused the death.	. Do not enter the	mode of dying, s	uch as cardiac or	respiratory arr	est,		Approximate Interval Between
sician	1	Immediate Cause (Final disease or condition	Cardiogeni	c Shock					(	Onset and Dea
dical		resulting in death)	a. Due to (or as a consequ							ne week
miner			Severe Isc	,	rdiomyon	athy			-	lears
	- le	Sequentially list conditions, if any, leading to immediate	Dua to (or as a consequ							Carb
sician and burial-transit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events								
ial-tr	Exa	resulting in death) Last	Due to (or as a consequ	ence of);		_	_			
	cai		d							
s the			u							
attending phy	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan					23d [	Date of delive	arv
for	ciar	in the past 12 months?	1 Live birth 2 ☐ Fetal 4 Pregnant at time of de		oic pregnancy or (specify)			3	Month	Day Year
ched	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	000000	, (opoony)					
ed by the detached	P	Part II. Other significant conditions co	entributing to death but not resul	Iting in the underly	ing cause given in	n Part I.	23e. Did to	bacco use co	entribute to ti	ne cause of death
00	d by	Ventricular Ta		-			1 🗀 Y	es 2□No	3 Prot	ably XXUnkr
should l	ete	Renal Insuffic	-							
SO	Completed		Tency				24a. Was a autops	SV	prior to co	psy findings avail mpletion of cause
pag	Co	Diabetes					1 X Yes		death?	2□ No
is certificate director, pag	Be	25. Was case referred to medical examiner?				. Place of Death	(Check only on	0)		
© .≘	2	1 ☐ Yes 2 📉 No	Hospital: 1 🔀 Inpatient 2 🗆 E	R/Outpatient 3	DOA Other:	4 Nursing Hom	e 5 🗆 Reside	ence 6 🗆 C	ther (Specif	y)
After th funeral	ü.	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	2	8d. Describe ha	w injury occ	urred	
tor: A the fu	atic	2 Accident investigation		М	1 🗆 Yes	2 □ No				
b 6	ti li	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street, fa	ictory, office	2	Bf. Location (Si City or Town	reet and Nur	mber or Rura	l Route Number,
o pe	Certification:		January,				,	,,		
To the Funeral Dir completely filled in		29a. Certifier XX Certifying Phy	vsician: To the best of my know iner: On the basis of examinati	rledge, death occu	rred at the time, o	date and place, a	nd due to the c	ause(s) and i	manner as s	tated.
letel	edical	(Check only 2 Medical Exam	and manner stated.	on and/or investiga	ation, in my opinio	on, death occurre	d at the time, d	ate and place	a, and due to	the cause(s)
omb	M	29b. Signature and title of certifier	1.		29c. License nu		2	9d. Date sign	ned (Month,	Day, Year)
			VW2		D379	360		April	23, 2	005
- 0		$\mathcal{L}$	V		7 /	100				
	+	30 Name and address of narson who o	omniated cause of death (Itam	23a) (Tuna Print)						
+1		30. Name and address of person who o Dennis J. Donohu					MD 200	11.2		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician**  $\overline{21}$ 2005 De 50 12:15 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 2124 5. Social Security Number imono If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Min. 1**∑**M 2□ F Hours 229-01-7141 Yrs Director S.C. Usual Residence of Decedent death with the Marylend 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 11☑ Yes 2 ☐ No Director Md N/ABalto 10e Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 2124 Braddish Avenue 21216 US Funeral Α 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on the 14 Health and Mental Hygiene. The 1f item 27 is marked other than "natural", or item 1 ☐ Never Married 2 ☐ Married 1√ Ves 2 □ No If Yes, Give 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bethelehem Steel Crane Operator 4th grade N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rivers Ellison Evelina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Ellison - Wife 2124 Braddish Avenue Balto, Md 21216 Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Garrison Forest Veteran 4-29-05 Owings Mills, Md 21. Signature of Funeral Service Liquesee 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, Md 21215 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Demontia Examiner Due to (or as a consequence of) Examiner nding physician and use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760. the attending physician Fews10N Physician/Medical Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by to 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen ( has 1 Yes 200No 1 ☐ Yes 2 ☐ No this certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check on) one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Hesidence 6 Other (Specify) 1 ☐ Yes 2 No 2 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 Yes 2 🗆 No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person completed cause of death (Item 23a) (Type, Print) 10 N GREENE St. BAKTIMORG. 9 31. Date filed (Month/Day, Year, 32. Regi State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No: 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 1:00P. Month **Physician** 2005 lliam 1001 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ALTI MORE Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) If Linder Birthplece (State or Foreign Country) 5. Social Security Number Days **Funeral** 1 M 2□ F Months Hours 6Q 32-782 Yrs MARY Director 10c. City, Town or Location 10d. Inside City Limits the Maryland 10b. County 7 28a-f show 10a State 1 ☐ Yes 2 No ARKVILLE BALTIMORE Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number rat', or items 23a or 3 21234 ve Completed by Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amped Forces? 1 Tyes 2 No 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: If #es, Give Year or Dates: 3 Widowed 4 Divorced "natural", permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natur any injury or other fraumatic event, the Medical ance. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ommunications 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Henry မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (T. e, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State racky, 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility BALTIMORE, MO 23a. Part T. Enter the disease or complications that caused shock, or heart failure. List only one cause on each lin TUANS FUNERAL CHAPOL 8800 HARFORD RO Approximate Int Between set nd Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Physician resulting in death) /Medical 200 Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 Unknown ☐Yes 2☐No 24a. Was an abtopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has this certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2V No 4 ☐ Nursing Home → Residence 6 ☐ Other (Specify) 9 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification After Natural Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month) Day, Year) 29b. Signature and title of certifie (Type, Print) 30. N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Aprith 2005 9:15 Ам **Physician** Henry Gause /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Mariner Health Of Glen Burnie Glen Burnie Anne Arundel Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Dec. 31 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F Days Hours 212-28-3037 Yrs. MD 75 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location s 23a or 28a-f show Glen Burnie 1 Yes 2 No Anne Arundel Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with til Department of Health and Mental Hygiene. Importent: If item 27 le marked other than "neturel", or items 23a or 2; may injury or other treumetic event, If a Madical Examiner must recons. 21060 IISA 724 Seagrove Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1951 – If Yes, Give Year or Dates: 1953 1 X Never Married 2 ☐ Married White 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Allen Katherine Frederick С. Gause 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 908 Langley Road, Glen Burnie, MD 21060 Mary Jones (niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) Aprilate 28 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 2005 Baltimore, MD Metro Crematory Inc. \* 4 ☐ Donation 5 ☐ Other (Specify) Stallings Funeral Home, 22. Name and Address of Facility 21. Signatur of Funeral Service Consee 3111 Mountain Road, Pasadena, MD 21122 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that saus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that in (Disease or injury that in (Disease) and the cause of the Due to (or as a consequence of): Examiner To the Hospitel or Attending Phyeician: The law requires that the death certificate be executed **burial-transit** Due to (or as a consequence of) Box 68760, by Physician/Medical IF FEMALE: for use 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day in the past 12 months 5 Other (specify) 1 ☐ Yes 2 ☐ M P.0. 9 MInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 4785 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2[] No 2 3 M 1 Tes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 | Inpatient Other: 4 Dursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ NO 3□ DOA 2 ER/Outpatient Certification: To 28d. Describe how injury occurred 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 5 Pending 1 Natural 2 🗌 No 1 Yes investigation death. 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Vithin 24 hours are To the Funerel Dir 1 fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of

State Registrar 30. Name and address

31. Date filed (Month, Day, Year)

(Item 23a) (Type, Print

who completed cause of deat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 02 2005 CARL LEE GENTILE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1∏ M 2□ F Months Days Hours Yrs. 62 JUNE 24, NY 119.30.2813 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No UTICA NY ONEIDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13502 USA 23 HIGHVIEW DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2XXMarried 2 No 1 🗆 Yes Specify 3 ☐ Widowed 4 ☐ Divorced ΧX WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MEAT DEPARTMENT MANAGER 12 SUPER MARKET 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) FRANCES DENIGRO ALBERT GENTILE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 23 HIGHVIEW DRIVE UTICA, NY 13502 PATRICIA GENTILE 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition CHENANGO VALLEY 5.2.2005 EARLVILLE, NY 21. Signature of Funeral Service Lice FINK FUNERAL HOME, P.A. GREGORY FINK MO1148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 Approximate Interval Between Onset and Death 23a. Part1 Enter the dishase or form lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List only the cause on each line. Immediate \ use (Final disease or c ition resulting in death) Due to (or as a confequence of): Backere Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 ☐ No 2 1 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Department 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🔲 Suicide

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Directo

Completed by Funeral

Be

Physiclan/Medical Examiner

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Be Completed

Certification: To

Medical

4 \ Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) APR 2 9 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a Certifier

**Funeral** 

Director

27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar manter by notified at

with the Maryland

Baltimore, Maryland 21215-0036

should be

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rn any Injury or other traum once.

Physician /Medical

Examiner

use as the burial-tran

for

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page 2

filled in by the funeral director,

completely

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signed by

attending physician and

The law requires that the death certificate be executed or Attending Physician: death. after death Director: within 24 hours a

> State Registrar DHMH 17 Rev 1/2001

> > **ORIGINAL**

9

32 Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene ) 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Ober t Gavin 04 7m5 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University of Maryland Hospital 7. Age (In yrs. last birthday)
Yrs. 1 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year)
Aug. 27, 1927 N/A Birthplace (State or Foreign Country)
 New York 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F 119-22-0321 Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland if Hygiene. other than "natural", or Items 23a or 28a-f ehow 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ebow the Medical Examinational be redified at Baltimore Maryland Catonsville 1 ☐ Yes 2 XNo Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 603 Maiden Choice Lane 21228 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Roman Catholic Priest Church permit, Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is markad oth any loury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Raymond Gavin Anna McFeelev L. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fellow -Priest Rev. Ronald D. Witherup 5408 Roland Ave. Baltimore. Maryland 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Sulpician Cemetery 4/30/05 Catonsville, MD 21. Signature of Funeral Service/Ligensee 22. Name and Address of Facility Baltimore, Maryland 21214 Z. Harton Tan 5305 Harford Rd. Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that you'ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) filmosis Pulmonary Physician ZWEEKS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 □ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Disease 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1X Yes 2 □ No 2**X** No or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3□ DOA this the funeral 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 15090 4/23/2005 Mary am 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) faltmere MD South 32. Registrar's Signature 31. Date filed (Month. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 Month **Physician** Gerald August Glaubitz April 26, 1:24 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Southern Maryland Hospital Clinton George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Nov 23, 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 1₩ 2□F 84 578 40 0670 Director Murdock. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, I're Manical Examinations to notified at 1 Yes 24 No Maryland Prince George's Morningside Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4507 Maple Road 20746 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYYes 2 □ No WWII If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 US Naval Research Lab Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mabel Marie Steel Frank Glaubitz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4507 Maple Road, Morningside, Maryland 20746 Jean L.Glaubitz (Wife) If item 27 i 20b. Place of Disposition (Name of cometery, crematory or other place) April 29,2005 20a. Method of Disposition 20c. Location - City or Town, State 5 120 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Maryland Veterans Cemetery • 4 □ Donation 5 □ Other (Specify) Cheltenham, Maryland 22. Name and Address of FacilityLee Funeral Home, Inc 663301d 21. Signature of Funeral Service Licenses Kierla D. Dibbo m01284 Alexandira Ferry Rd, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an certificate has autopsy 1□ Yes 2 1 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA this 28c. fnjury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After To the Hospital or Attending 1 Natural fnjury 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 29a. Certifier 1/2 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

completely

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

11701 Caine MD 31. Date filed (Month, Day Year) 32. Regilirar's Signature 2005

Hame and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and the of certified

aroline

29c. License number

29d. Date signed (Month, Day, Year)

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			Decedent's Name (First, Middle, Last)				2. Date of Death	= 0 13 3	3. Time of Death
	Physicia	_	George Lawrence	e Gorney			Month April 2	Day Year 21, 2005	7:30 A.M
	/Medic Examin		4a. Facility Name (If not institution, give street and number	)	4b. City, Town, or L	ocation of Death		4c. County of Deat	
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	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year		8. Date of Birth (Month, Day,	9 Birt	hplace (State or Foreign untry)
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	D >		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or Lo	neation		-		10d. Inside City Limits
	sho	5	Maryland Baltimore	Baltimor					1 ☐ Yes 2 🙀 No
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Maryland	2 should be fil and Mental H Is markad oth raumatic even	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street an	d Number or Rura	Route Number,	City or Town, State, 2	Zip Code)
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E O	Paga ent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	9	Crematory	1	2, 2005	Baltimo	re, Maryland
Baltimore,	permit. Pagas : Department of H Important: If its any Injury or of once.		21. Signature of Fugeral Service Lidensee		Name and Address Chisholm Fu 200 E. Pade				Valley, P.A
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Re	he fa s has ge 2	E D					autopsy perform	prior to death?	completion of cause of
a		e Co	25. Was case referred to medical			GC Place of Dogsto	1 Yes 2		2 No
Vital	Phyaician: The faw this certificete has tral director, page 2 s	o B	examiner?  1 Yes 2 No  Hospital: 1 Inpa	tient 2 EH/Outpatie	Other	26. Place of Death  4 🗋 Nursing Hor		nce 6 □Other (Spe	cih.)
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Division	Attending or death. actor: After by the fune	fica	3 Suicide 6 Could not be 28e. Place of I	njury - At home, farm, st	treet, factory, office	1		eet and Number or R	ural Route Number,
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director.	edical Certification;	29a. Certifier 1 Certifying Physicien: To the beautifier (Check only 2 Medical Examiner: On the basis	of examination and/or in	th occurred at the time	e, date and place, a inion, death occurre	and due to the ca ed at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
	thin 2 the the mple	Med	one) and manner 29b. Signature and title of certifier	stateu.	29c. License	number	29	d. Date signed (Mont	h, Day, Year)
	F 3 F 8		MADGIA -	ilwo		, 639		4/21/2	005
5	11		30. Name and address of person who completed cause o	death (Itom 22a) (Time-		<del></del>		1 4 7	
Υ -	) (		MANY GOLDSTEIN MD	7 DS C	oscen Di	RIVE 17	103, TC	WWW MC	2)204
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Regis	Strate Signature	Sperte				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** Earlene Louise Harris April 24, 2005 9:49 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince George Laurel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2X ☐ F Months Days Hours Min 64 Director 213-40-3292 September 1,1940 Maryland Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Itam 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the notified at once. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 B Rose Street 20724 USA Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Amed Folces? 1 ∐Yes 2 [X] No If Yes, Give Year or Dates: 1 Never Married 200 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Calvin Pryor Martha Louise Griffith ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jackie Ray Harris / Husband 1 B Rose Street, Laurel, Maryland 20724 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State tXX Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 4/28/3005 Elkridge, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Fleck Funeral Home, Inc. m00869 7601 Sandy Spring Road, Laurel, Maryland rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition Acute Myocardial Infarchion 3 Hours resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 99 1 Yes 2 No 3 Probably 4 Unknown Hypertension Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s 1 Yes 2**X** No Division of Vital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No P 1 Inpatient 2 X ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Diractor: A investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature al rson who completed cause of death (Jem 23a) (Type, Print) address of Bellineve Ave Lawel, MD 20707 TARGOLIS pgistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL **Physician** 25, ANNA MARIA ELIZABETH HIEBLER 2005 9:40 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner TOWSON BALTIMORE PICKERSGILL RETIREMENT COMMUNITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/17/1912 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 13 E 92 216-12-9680 Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No BALTIMORE MD TOWSON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 615 CHESTNUT AVENUE 21204 USA Items 23a Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY BALTIMORE COUNTY 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I and Mental CHARLES A. RIEDEL ROSAMUND BECK 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any in ury or other tra once. HENRY G. HIEBLER, JR./ Son 30 WINEHURST WAY CATONSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. 4/28/2005 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Tlea 8521 LOCH RAVEN BLVD. TOWSON, MD Colemas 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due th (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? ξ Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. | detached Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No Certification: To 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 124 hours after death the Funeral Director: A pletely filled in by the fi 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2. To the I 29b. Signature and title of certifier pleted cause of death (Item 23a) (Type, Print) Charles St. Balto. Md 2,20% 6701 MC Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene 4583 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** John Mathew Hurban 7,2005 APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**⊠** M 2□ F 195-26-5962 72 26, Director Pennsylvania Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits ral', or Itams 23a or 28a-f show Examiner must be nutified at 1 ☐ Yes 2 No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Woodland Drive 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □X/es 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced "natural', White leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Compl other than Elementary/Secondary (0-12) College (1-4or 5+) 4 Mechanical Engineer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If itam 27 is marked oth any injury or other traumatic avent 2008. Be ပ္ Mary Catherine Moncman Matthew Paul Hurban 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rose Marie C. Hurban / Wife 201 Woodland Drive, Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Indiantown Gap Nat'l Cem. 5-3-05 Annville, Pennsylvania \* 4 □ Donation 5 □ Other (Specify) 21. Signature & Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** BILATERAL SEVERE /Medical YOCARDIOL INFORCTION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Box 68760 Completed by Physiclan/MedIcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4 Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Diractor: After Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 0 within 24 hours a To tha Funaral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 26191 Chee 2112 BELAIR ROAD SUITEID, FALLSTON, MD 21047 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & ANUSHA. SIRITHARA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 9 2005 Registrar

#05260 HURBAN

KI	ΧD		For State Registrer	State of Ma	aryland / Dep <i>Ce</i>		of Health <i>of Death</i>		_	ene g. No. 0 (	5	1456	34.
			Decedent's Name (First, Middle, Last)						2. Date of Death	1	V	3. Time of D	)eath
	Physicia /Medic		Charles Winton	Hudler	II				APRTL	26, 20	005	1:51P.	. M
	Examin		4a. Facility Name (If not institution, give s UPPER CHESAPEAKE MI	,	NTER		own, or Location LAIR	of Death		4c. County			
	Funeral Director		210 40 2000	7. Age M 2□F	6 (In yrs. last birthday 56 Yrs.		Year If Unde Days Hours	Min.	8. Date of Birth (Month, Day, Dec. 9,	<sup>Year)</sup> 1948	Cour	place (State or I ntry) yLand	Foreign
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation					Ţ,	I0d. Inside City	Limits
	Mary! -f sho	tor	Maryland Harford		Bel Air							1 XYes 2	2 🗌 No
	n the	Director	10e. Street and Number			10f. Zip C	ode		10	g. Citizen of V	What Cour	ntry?	
	th wit	al D	150 McCormick St	reet			21014			US	SA		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Heatth and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic evant, Its Medical Examinat must be notified at	by Funeral	11. Marital Status 1  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	2. Was Decedent I Armed Forces? 1 XYes 2 ☐ N If Yes, Give Year or Dates:		Was Deceder If Yes, specify 1 ☐ Yes 25	nt of Hispanic O Cuban, Mexica		ify Yes or No- lican, etc.)		ck, White,		
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re,	s 1 and 2 of Health a Itam 27 is other trau		20a. Method of Disposition		20b. Place of Disp	osition (Name	of	Da		Oc. Location -			
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Baltimore,	permit. Pages 1 and Department of Healt Important: If Itam 2 any injury or other once.		21. Signature of Funeral Service License	ch		MCCOMA	ed Funer	al Hor	me, P.A. i, Abino		arvla	and 210	09
8760,	And price of the p	al Examiner	23a. Part <sup>1</sup> . Enter the disease, or complications, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any, leading to limitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):	etic (	-		co-Di		e	Approximate Interval Batwe Onset and De	en eath
.O. Box 6	the death certific y the attending p ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	⊒Ectopic prec ⊒ Other (spec				T.	te of delive	ery Day Yea	ar
rds, P.	es gu	by	Part II. Other significant conditions con	tributing to death b	ut not resulting in the	underlying cau	se given in Part	1.		acco use cont s 2 🗆 No	ribute to th	ne cause of dea pably 4 □Uni	
Vital Records,	The law ate has t page 2 s	Completed							24a. Was an autopsy perform		prior to co death?	psy findings av mpletion of cau	railable use of
/ita	Physician: This certifical ral director, p	Be (	25. Was case referred to medical examiner?					e of Death	(Check only one	)			
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Division	or Attan ifter deat Director: in by the	ertification;	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ury - At home, farm, s c. (Specify)				Bf. Location (Stre City or Town,		er or Rura	I Route Numbe	эг,
	Hospite 4 hours Funaral	Medical C	29a. Certifier (Check only one)  1 Certifying Phys 2X Medicel Exemin	icien: To the best of er: On the basis of and manner sta	of my knowledge, dea f examination and/or i ated.	th occurred at nvestigation, in	the time, date a my opinion, de	ind place, areath occurred	nd due to the car d at the time, da	use(s) and ma te and place,	inner as s and due to	ated. the cause(s)	
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier			29c.	icense number		29	d. Date signe	d (Month,	Day, Year)	
	ı Á		1 Cortes	W)			OCME		AF	PRIL 27	,200.	5	
	1041		30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Type		enn Stre	et R	altimor	e. Mary	vland	21201	
	Sta Registi	.76	31. Date filod (Month, Day, Year)  APR 2 9 2005	32. Registra	ar's Signature	de				,	, _ure	-1201	

Lillie Myers 05-01964 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. d1nd Mental Hygiene State of Maryland / Department of Healt 1- State Amend Item P per ME, G842, 04/29/05 That of Death (First, Middle, Last) 2. Date of Death 3 Time of Death Day Month **Physician** 2005 March 18. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1839 N. Durham Street Baltimore 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Min 78-58-96 Usual Residence of Deceden Hours Yrs. Director Vorth( Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ent: If item 27 is marked other than "natural", or Items 23e or 28e-f show ary or other treumatic event, the Medical Exercites in the netities of 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc ☐Yes 2 No 2 ☐ Married 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xe Specify 3 Widowed 4 Divorced ac Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. NO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) dary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last, 18 .Mother's Name (First, Middle, Maiden Sumame) Be 10 rma Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City of State, Zip Code) 20c. Location - City or Town, State od of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or of 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Vall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Complications of chronic alcohol abuse **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the l IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ Month Day Year in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) should be detached 9☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an page 2 s certificate has autopsy performed 2□ No To the Hospitel or Attending Physicien: in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 2 No 10 1 XYes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this scene 27. Manner of Death 1 X Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After 5 Pending investigation death. 1 Yes 2 □ No within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

tomeki E. Southaul. MD 31. Date filed (Month, Day, Year) 32. Registrar's Signat R 2 9 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Tamel

29c. License number OCME

111 Penn Street

29d. Date signed (Month, Day, Year)

March 19, 2005

Baltimore, Maryland 21201

			For State	State of Marylan				Mental Hy	giene		
ı	Physici	an	1. Decedent's Name (First, Middle, Las	1)			Death	2. Date of De Month	Day	Year	3. Time of Death
	/Medic	cal	4a. Facility Name (If not institution, give	Alfred Norma	n Judd		Location of Dea	April		OOS ty of Death	6.25 AM
	Examin	ier	Sina: Has Dita	1 0 0 11	Move	13. City, 10 mil, 5	- MOVE		40.00011	•	ore City
	Funeral		5. Social Security Number 6. Security Number 1	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bir	th y, Year)		place (State or Foreign
Ľ.	Director		017-20-8558	¶M 2□F 7	8 Yrs.	Monard Bayo	110013	October 2			sachusettes
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation			-1		0d. Inside City Limits
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	th the	Director	Maryland Balt 10e. Street and Number	IIIIOI.E		10f. Zip Code	OUGSTOCK		10g. Citizen o	f What Cour	ntry?
	death with the Maryland ms 23a or 28a-1 show rowst be notified at	ral	10232 Harvest Fields D				21163			U.S.	
	er de: Itams Cer m	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14. Ra	ace - Americ ack, White,	
0000	be filed within 72 hours after death with the Marylan ital Hyglene. Id other than "natural", or liams 23a or 28a-1 show avant, I'm Medical Evantrer must be notified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give A Year or Dates:		1□Yes 2X No	Specify:		Spec	eify:	White
	72 hou		15. Decedent's Ed (Specify only highest gra-	ucation	16a. Dece	dent's Usual Occup	ation	ndkina	16b. Kind of	Business/In	dustry
Ž	within 72 ene. than "nat	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	doning most of we	nkiig	L	J.S. Gov	ernment
V	iled w tygier har th		17. Father's Name (First, Middle, Last)	4+		Industr	ial engineer		Maidan Sum	ama)	
	uld be fi fental H rked ot ilc avai	Be c					TO. MOUTHER S IN A			,	
5	2 should be and Mental Is marked raumatic av	2	Franklin Fr 19a. Informant's Name/Relationship (7	merson Judd Гурө, Print)	19b. Mailir	ng Address (Street	and Number or F		beth Lesc er, City or Tow		Code)
2	and 2		Ms. Shirley Ann Judd	Wife	1	0232 Harves	t Fields Driv	e Woodstoc	k. Marvlan	d 21163	
anmore,	- T a =		20a. Method of Disposition  1 Burial 2 Cremation 3	20b.	Place of Dispo	osition (Name of matory or other place		Date	20c. Location		
Ē	Pages ment of ant: If it ury or o		* 4 □ Donation 5 □ Other (Specify	)	Mount	View Cemet	AND THE RESERVE TO THE PARTY OF	4/23/2005	Marr	iottsville	, Maryland
משו	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licen	6/	22	2. Name and Addre	ss of Facility	D 4			
	E0 = e 0		23a. Fart1. Enter the disease, or com	plications that caused the dea	th. Do not ent	Slack F 3871 C	uneral Hom	ie, P.A. Pike Ellicot	t City, MD	21043	Approximate
	£5.		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.							Interval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death)	a. ACUTE  Due to (or as a conse		o Card	icu / /	Itarc	HOVI		5 days
	Examiner		Saguestially list conditions	h							
1	ם א	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):						
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	quence of):						
8/60,	cate be executed physician and the burial-transit	ai E			querios oi).						
20	ificate p phys as the	edicai		d							
XOD	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		∃Ectopic pregnanc	,		23d. E	ate of delive	•
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		Other (specify)			٨	<b>Month</b>	Day Year
r Ö	that the de ed by the a detached I	Phys	9 Unknown				· · · · · ·	02- File			ha causa of de ship?
	ires tha signed t be de	by	Part II, Other significant conditions of	ontributing to death but not re	sulting in the u	inderlying cause giv	en in Part I.		Yes 2 □ No		he cause of death?
Ö	w require been si should b	Completed							2.7		
Records,	The law ate has page 2 s	mpi						24a. Was auto perfo	psy omed?	prior to co death?	psy findings available mpletion of cause of
_		e Co	25. Was case referred to medical				26 Place of De	1 ☐ Yes eath (Check only o	2 No	1 ☐ Yes	2 No
>	ysician: is certific director,	0 B	examiner?	Hospital: 1 XInpatient 2	ER/Outpatie	nt 3 DOA Ott	0.00	Home 5 ☐ Resi		ther (Specif	<b>'v</b> )
0	ding Ph h. After th funeral	n: T	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	of 28c. Injur	ry at	28d. Describe			
Division of	eath. or: Al	catic	2 Accident investigation	9			Yes 2 □ No				
ž	or Attendated after death Diractor:	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, st	reet, factory, office		28f. Location ( City or To		nber or Rura	al Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1 Certifying Ph	vsician: To the best of my kn	owledge deal	th occurred at the ti	ma, data and plan	ce, and due to the	cause(s) and	manner as s	tated.
	a Hos 24 hc a Fun etely	edical	(Check only 2 Medical Exar	ysician: To the best of my kn niner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my	ppinion, death occ	curred at the time,	date and place	e, and due to	the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier	1- 1-2		29c. Licens	se number		29d. Date sign	ned (Month,	Day, Year)
	í		Rolf tour	-n, MD		_   Re	5 660		April	19,	2005
	P		30. Name and address of person who		em 23a) (Type,	Print) Hospi	1.1.0	0. 1.13	MARKO		
	1			32. Registrar's Sign	Sino	1. Hospi	tal 0t	- Ralt	AMOLE		
	St Regist	ate	31. Date filed (Month, Day, Year) APR 2 9 2005	32. Hegistrar's Sign	lature	60					

JET 05-02878 Belinda Kinsey

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 20<u>05</u> **Physician** Year 25 3:15 Рм BELINDA KINSEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland General Hospital E/R Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖾 F Yrs. Director 49 551-90-7950 JULY 8 1955 CALIFORNIA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show The Modical Executives trust be notified at 1 ☐ Yes 2 🛣 No Director MARYLAND BALTIMORE ESSEX 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 21221 1443 HADWICK DRIVE U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. s 1 and 2 should be filed within 72 hours after f Health and Mental Hygiene. item 27 ts marked other than "netural", or Ite 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATOR STATE OF MARYLAND 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SAMUEL KINSEY ANNE MAE BREAUX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaRhonda A. Jordan/Daughter 3 Neves Ct., Baltimore, Maryland 21234 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any injury or ott cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ` 4 □ Donation 5 □ Other (Specify) METRO CREMATORY 05-05-05 BALTIMORE, MARYLAND 21. Signature of Fundral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Wash complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a Part 1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final sease or condition resulting in death) Pnysician Hyportensive cardiovascular atheroscientic /Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (un as a consequence of). ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine equires that the death certificate be executed as the burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) bed ( Yes 2 □ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munknown been si leted 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2□ No 24a. Was an autopsy performed? certificate 1X Yes 2 No Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1X Yes 2 □ No 1 Inpatient 2X ER/Outpatient 3 DOA this funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending death. investigation М 1 Yes 2 No or Attendation of the death of 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*CXMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier hi, m.0 OCME April 26 2005 n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Reistrar's Signature State APR 2 9 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARIE L. KRONAU APRIL 28, 2005 8:21 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HART HOMES ASSISTED LIVING LUTHERVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 □ M 2 🖸 F 216-12-3826 83 6/2/1921 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits Maryland 10b. County 10c. City, Town or Location 10a. State rai", or itams 23e or 28e-f shov Examiner must be notified at 1 ☐ Yes 2X No BALTIMORE TOWSON Directo the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1577 DOXBURY ROAD 21286 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: þ If Yes, Give Year or Dates: WHITE 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic evant, The Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. STATE OF MARYLAND BUDGET ANALYST YEARS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental PERCY H. LAZAR ELIZABETH R. THOME ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8 permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other trau once. 1577 DOXBURY ROAD TOWSON, MD 21286 REGINA K. SHEA/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD CEMETERY 5/2/2005 BALTIMORE. MD A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Lay Hu 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 2 heriners Ca disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of a Examiner certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-t attending physician Physiclan/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) \_ the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Henry Home examiner Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Assisted Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 XNo Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Diractor: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 T Homicide Hospital Textifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a, Certifier within 24 ho

To tha Funs

completely f 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 ddress of person who completed cause of death (Item 23a) (Type, Print). 6761 N. Charles St. Bolto Md 21204

Registrar DHMH 17 Rev 1/2001

State

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Box

P.O.

legistrar's Signature

R 2 9 2005

			For State Registrar	State of Ma	aryland / De <i>C</i>	partment e <i>rtificate</i>			nd Me		jiene	005	14589
			Decedent's Name (First, Middle, I						2	. Date of Dea	th		3. Time of Death
	Physicia		RONALD	L. +	<ing< td=""><td></td><td></td><td></td><td></td><td>April</td><td><math>25^{Day}</math></td><td>2005 Year</td><td>2:22 P.M</td></ing<>					April	$25^{Day}$	2005 Year	2:22 P.M
	/Medic Examin		4a. Facility Name (If not institution, g	rive street and number)		4b. City, T	Town, or	Location of				county of Death	-1
	Examin	٠,	6201 Loch Raven	Blad Apt 60	11	Balt	imo	re					
	Funeral		5. Social Security Number 6	Sex 7. Age	e (In yrs. last birthda	y) If Under 1		If Under 2	24 Hrs. 8 Min.	. Date of Birth	Year	9. Birth	place (State or Foreign
	Director		212-36-7626	1 □ AM 2 □ F	65 Yrs.	Months	Days	Hours	MIII.	(Month, Day	193	9 Mary	Tand
	p ,		Usual Residence of Decedent		10c. City, Town or	Lanation							10d. Inside City Limits
	shov	_	10a. State 10b. County		Baltimo								1 Yes 2 □ No
	Me M	Directo	Maryland		Bartina		2.1				10- 011		
	with t		10e. Street and Number 6201 Loch Raven	Pland Ant 6	01	10f. Zip (	212	30			USA	en of What Cou	muyr
	hours after death with the Maryland tural; or Items 23a or 28e-f show al Ever it ar must be notified at	Funerai		12. Was Decedent		3 Was Decede			in? (Speci			4. Race - Amer	ican Indian
_	Item Item	'n	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Married</li></ul>	Armed Forces?	10	3. Was Decede If Yes, speci	fy Cuba	n, Mexican,	, Puerto Ri	can, etc.)		Black, White	, etc.
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Ş	d within 72 hours after death with the Marylan jiene, than "natural", or Items 23a or 28e-f show the Medical Ever it we must be notified at	ted	15. Decedent's		16a. De	cedent's Usual	Occupa	ation	of unding		16b. Kin	d of Business/li	ndustry
9500-61212	within 72 ene. than "na	pie	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	life	DO NOT use	e retired	dining most	di working	'			
7	ifiled withir Hygiene. other then rent, I're M	Completed	12			istrat	ion					Force	
2	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, La	ist)						First, Middle,	Maiden S	Su <i>mame)</i>	
<u>X</u>	Ment Ment arked atic	2	Fritz King					Lel	ah Bi	shoff			
Maryland	and and Is m		19a. Informant's Name/Relationship	(Type, Print)	19b. M	ailing Address	(Street a	and Numbe	r or Rurai F	Route Numbe	r, City or	Town, State, Zi	p Code)
≥	es 1 and 2 should be filed w of Health and Mental Hygier If item 27 is marked other th ir other traumatic event, the		Tracy Ray King	Son		Loch	Rave	n Blv	d_Apt	601;	Falt	imore, ation - City or T	NII 21239 own, State
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altimore,	Pages ment of tant; If it tury or o		' 4 □ Donation 5 □ Other (Spe		Arlingto				6/200	)5 <i>A</i>	Arlin	igton, V	/irginia
Bai	permit. Page Department of Important; If eny injury or once.		21. Signatur			Sterl:	d Addres $\mathbf{ing}$	ss of Facility Ashto	n Sch	wab Fu	ınera	1 Home,	Inc. D 21228
	70 5 0 O		C y	//-	1290							ille, M	
		Œ.	23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that caused by one cause on each lin	ne.	enter the mode	e or cryin	ig, such as	cardiac or i	respiratory an	rest,		Approximate Interval Between Onset and Death
	Pnysician	S 1	Immediate Cause (Final disease or condition resulting in death)	a. Met	astatic	tauc	160	25 (	dure	MON	va_	- 3	14 man
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):								
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	led Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 (5) (5)	a consequence on,								
/_	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):								
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89	ificate I g physi as the b	0											
ŏ	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 □Ectopic pre					23	3d. Date of deliv	very
m.	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		5 ☐ Other (spe			<u> </u>			Month	Day Year
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Vital Records,	2 5 8	Completed								24a. Was autop		24b. Were aut	opsy findings available ompletion of cause of
Ĭ	The I	mo;								perfor	med? 2 No	death? 1 ☐ Yes	
a	siclan: Th certificate rector, pag	Bec	25. Was case referred to medical				135	26. Place	of Death (	Check only o	ne)		
	nysic tis ce direc	ToE	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	ent 2 ER/Outpa	tient 3 DO	A Oth	er: 4 🗆 Nu	rsing Home	e 5 🕰 Resid	lence 6	☐Other (Spec	rfy)
0	Attending Physiclan: r death. ector; After this certific by the funeral director,		27. Manner of Death  1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Tim y Year) Inju		8c. injur Wor	y at k?	28	d. Describe h	ow injury	occurred	
0	death. ctor; A	atic	2 Accident investiga			М	1 🗀	Yes 2 1	- 12				
Division of		Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home, farm. c. (Specify)	street, factory	, office		28	of, Location (S City or Tow		Number or Rui	al Route Number,
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	To the Hospital within 24 hours a To the Funeral Completely filled	Med	29b. Signature and title of certifier	and mailled St		29c	. Licens	e number			29d. Date	signed (Month	. Day, Year)
)	F 3 F 8		Caronlos Na	doethur			Die	5546			APR	IL 26 .	2005
	141		30. Name and address of person w	ho completed cause of o	death (Item 23a) (Ty 560) Lar's Agnature	pe, Print)				0.1	•	•	
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	Regist	rar	A	PR 2 9 2015	DIMUES	N. 19							

# Baltimore, Maryland 21215-0020

# Division of Vital Records, P.O. Box 68760,

	Please Type or Print in Black Indelible Ink. Assure All State of Maryland / Department of Health and Me	•	_	
	AMEND ITEM #5 PER FH C843 5/19/05 Gertificate of Death		g. No.2 11 11 5	Lisan
	Decedent's Name (First, Middle, Last)	2. Dete of Deeth	1	3. Time of Death
Physician /Medical	Dennis Lloyd Krebs	Month April 2	Dey Year 2005	4:20AM
Examiner	4e Facility Name (If not institution, give street and number)  4b. City, Town, or Loc	cation of Death	4c. County of Deat	h
	Westminster Nursing Westmins		Carro	
Funeral	Months Days Hours Min	8. Date of Birth (Month, Day,	Year) Co	hplace (State or Foreign untry)
Director	Usual Residence of Decedent	Oct. 4,	1942	MD
yland Mor	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
o Mer	MD Baltimore Owings Mills			1 □ Yes 21∏ No
vith the Me t or 28s-f a be notified Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	untry?
eth w	253 Cedarmere Circle 21117	-# - W N -	USA	dana Indian
fler deeth ver trems 230 chec must	11. Maritel Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  2 ☑ Married  1 ☑ Yes 2 □ No	Rican, etc.)	14. Race - Ame Black, Whit	
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thould ad Men mark	Lloyd Krebs Helen  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura)	Eyler Route Number.	City or Town. State.	Zip Code)
ad 2 s lith er 27 la r trau	Nancy L. Krebs Wife 253 Cedarmere Circle,			21117
s 1 er f Hea ttem other	20a. Method of Disposition 20b. Place of Disposition (Name of		Oc. Location - City or	
Page nent o	1 M Burial 2 Li Gremation 3 Li Hemoval from State	/30/05	Sykesvi	lle, MD
Department of Health and Mentel Hygiene "Department of Health and Mentel Hygiene "Department of Health and Mentel Hygiene "Department of Health and Mentel Hygiene "Inportant: If Nem 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumstic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	21. Signeture of Funeral Service Licensee 22. Name and Address of Facility		Reisters	
8255	Eline Funeral Home		erstown, l	
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Physician				Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  e. Metastatic Colon Cancer			3 7/2
<b>6</b>	Due to (or as a consequence of):			9
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icete be exphysician s the buna	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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yalclan: The lev sertificate has director, page 2 To Be Comp	25. Was case referred to medical examiner?	(Check only one	9)	
Attanding Physician: r death. ector: After this cartific by the funeral director, ification: To Be (			nce 6 Other (Spe w injury occurred	cify)
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tal or Attanding P rs efter death. al Director: After t ed in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town,	, State)	
	29a. Certifier  (Check only  Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred	and due to the ca	use(s) and manner as	s stated.
the Hospi nin 24 hou the Funer hpletely fill	one) and manner stated.			
To the troop com	29b. Signature and title of certifier  29c. License number	29	d. Date signed (Mont	n, Day, Year)
•	Dahah Imano Do H53939		4/20/	2
int/	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  Babak Imancel, DO 412 Malcolm Drive; Srik	304: W.	estmin Her	MD 21157
State	31. Date filed (Month, Day, Year) 32. Restrar's Signature	- ()	, 1,0,0,	/ د و
Registrar	APR 2 9 2005 Scene 1 19			

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM #7 PER FH C842 4 Periosate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year 12:55a M 27 2005 April JANICE LEIGHTON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** VILLA\_ST. MICHAELS NURSING HOME BALTIMORE
If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days 1 ☐ M 2 🛣 F Hours 49 Director MARYLAND AUG 5, 1955 213-64-5515 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Exerciser must be notified at 1 X Yes 2 No Director BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 1018 N WOODINGTON ROAD U.S.A. filed within 72 hours after death Funeral Items ; 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOME CARE HOMEMAKER 12th grade permit. Pages 1 and 2 should be filed Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumattc event, IL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES LEIGHTON MABEL RILEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1018 N. Woodington Rd., Baltimore, Md. 21229 Derek Leighton/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) MT ZION CEMETERY 04-30-05 LANSDOWNE, MARYLAND 21. Signature of Therat 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 0 Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physiclan/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 — Yes 2 — No 2 Fetaf death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 217 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) tuneral 28c. Injury at Work? 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation hours after death 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Live 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. MVELLBA 413 Comm 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State APR 2 9 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend items 23a 27 per phys 842 4-20 05 yellow State of Maryland / Department of Health and Menta Maygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **∆**Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Nous Ballimore If Under 1 Year | If Under 24 Hrs. South 6. Sex. 12 M 2□ F Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 212-44-2183 Usual Residence of Decedent Yrs. Director 6 MARYLAND Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: if time 27 is marked other then "natural", or iteme 23a or 28a-1 show ury or other treumatic event, its Mcalcal Exemplant ment be notified at 10c. City, Town or Location 10a. State 10b. County 10d. tnside City Limits 1 Yes 2 No BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 01 Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 □Yes 2 No If Yes, Give Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 4 Divorced white 3 Widowed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawing 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State Zin Code 2040B Collinger Finksburg R-SON 20b. Place of Disposition (Name of cemetery, crematory of other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department o Importent: ff any injury or once. Forest Hill EVANS FUNERIAL HAPEL-21. Signature # Funeral Service Lie 22. Name and Address of Facility BACTIMORE, MD 2123 23a. Part.1 / Enter the disease, or/completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tomaddus Cause (Text). Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) Physician ARIDIAC AFFEST cardiac arrhythmia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). by Physician/Medical Examiner for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be exec Due to (or as a consequence of): Box 68760. tF FEMALE: tf yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Year Day 5 Other (specify) P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, KNYNOWN 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Yes 2 No Yes 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending after death. Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident Gould not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a
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completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DEA! 888094562 26/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOONYASAI 21224 4940 EASTERN AVE MD BALTIMORE ROMSA 1 31. Date filed (Month, Day, Year) APR 2 32. Registrate Signature State Registrar

		•	For State Registarrer	nd item	State of per	of Maryl	and / Depa 2 4/29/R	artment of H	lealth a	and M		jiene2 ()	05	14593
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	Examin	er	Future Car		1	iniber)		0 1 10	1			4c. County	or Death	
- 12	Funeral		5. Social Security N	umber d.	Sex	7. Age (In )	yrs. last birthday,		If Under		8. Date of Birth	Year)	9. Birthp	place (State or Foreign
E.	Director	9	176-16-		1 <b>№</b> M 2□F	83	82 Yrs.	Months Days	Hours	Min.	July 2	3, 1921	Penn	isylvania
	and		Usuel Residence of 10a. State	10b. County		10c	City, Town or L	ocation					1	Od. Inside City Limits
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O	ding P. After fune	tion	1 ☑Natural 2 ☐ Accident	5 Pending investigat		of Injury onth, Day Yea	ar) Injury	Wor	k?" Yes 2□		EUG. DOSCHOO IN	ow injury occurr	90	
Division	If or Attending after death. Diractor: After d in by the funer	Certification:	3 Suicide 4 Homicide	6 Could no determin	t be 28e. Plac	ce of Injury ding, etc. (Sp	At home, farm, si pecify)	treet, factory, office			28f. Location (S City or Town	treet and Numb n, State)	er or Rura	al Route Number,
	Hospita 4 hours Funaral tely filled	edical Ce	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	caminer: On the	basis of exai	knowledge, dea	th occurred at the tin	ne, date an pinion, dea	nd place, a	and due to the c	ause(s) and ma	nner as s	tated. o the cause(s)
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	5		30. Name and add	ress of person wi	no completed ca	use of death	(Item 23a) (Type	, Print)	111	21	0.		-1	2/15/
				aftran 1	Kus hindr	Popietes de C	4 Busin	els (h	th 1	Don	1 Keist	the town	MO	71136
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Physici /Medic	cal	William Langsto	n		·		April	20, Day	005 Year	1:59 P
Examin	ıer	4a. Facility Name (If not institution, give Johns Hopkins Bayv  5. Social Security Number 6. Se	iew Hospita	1 yrs. last birthday,	4b. City, Town, or Balti  If Under 1 Year				ounty of Death	place (State or Fore
Funeral Director		225-560-3229	7. Age (In	60 Yrs.	Months Days	Hours Mi		ay, Year) - 4 4	VÄ	ntry)
of show	tor	10a. State 10b. County MD	100	c. City, Town or L Baltim						10d. Inside City Lim
or 28:	)irec	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cou	ntry?
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pernitt. rages I and Department of Health Important: if item 27 any injury or other ti once.		20a. Method of Disposition  1 Burial 2 Cremation 3 1  4 Donation 5 Other (Specify	Removal from State		osition (Name of matory or other place	θ)	Date - 26 - 05		tion - City or T	
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Medical be available to a page of a	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of):						
y the attending tched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Fetal death 3	□Ectopic pregnancy □ Other (specify)			230	d. Date of deliv	ery Day Year
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within 2 To tha I	Ž	29b. Signature and title of certifier	994		29c. License	e number			signed (Month,	
		) high	, m . D		OCME			April	21, 20	05
		30. Name and address of person who c	completed cause of death	(Item 23a) (Type	. Print) 111	Penn St	reet Ba	ltimor	e. Mar	vland 21:

			1 - For State Registrar	State of Maryland		artment of F			2005	11.505
			Hegistrar     Decedent's Name (First, Middle, Last)			tineate or	Death	2. Date of Dea	leg. No.6 UUU	3. Time of Death
	Physici	an						Month	Day Year	
	/Media		Robert L. Lohman			41 Ch T			25, 2005	4:05P M
	Examin	ier	4a. Facility Name (If not institution, give st				r Location of Death	1	4c. County of Death	
			Wilson Health Car  5. Social Security Number 6. Sex	7. Age (In yrs. las	t hirthday)	Gaithe:	rsburg   If Under 24 Hrs.	8. Date of Birtl	Montgome	
	Funeral			M 2□F 82	Yrs.	Months Days	Hours Min.	March S	(Year) Cou	place (State or Foreign intry)
-	Director		Usual Residence of Decedent	02				march 5	, 1925 New	York
	land ow		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Man, f sh	to	Maryland Montgomen	·v Gai	thers	hurg				1 X Yes 2 No
	7 288	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of What Cou	intry?
	30 o	Funeral Director	419 Russell Avenue	#402		20877			United Stat	T A S
	death ms 2	Jere		2, Was Decedent Ever in U.S.	13.		lispanic Origin? (S an, Mexican, Puert	pecify Yes or No-		ican Indian,
9	after or ite	F	1 ☐ Never Married 2 ☑ Married	Armed Forces?  1 ⊠Yes 2□No Wor]  If Yes, Give	ld '			o Hican, etc.)		, etc.
8	be filed within 72 hours after death with the Maryland ital Hygiene. ad other then "naturel", or ttems 23e or 28e-f show event, the Madical Extention of the matter at the malified at	by	3 Widowed 4 Divorced	Year or Dates: War	II	1□Yes 2█ No	Specify:		Specify:	hite
21215-0036	72 hc	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual Occup	nation during most of wor	kina	16b. Kind of Business/Ir	ndustry
2	thin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. i	DO NOT use retire	d)	9		
N	filed with Hygiene. Ither the	Con		4	Aeron	autical			Federal Gov	vernment
D D	tal Hydral Hydral double	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Sumame)	
<u>ya</u>	should be and Menta marked umatic ev	2	William H. Lohman				Viola			
Maryland	2 sho and Is m		19a. Informant's Name/Relationship (Typ	-		-			r, City or Town, State, Zi	
	s 1 and 2 should f Health and Men item 27 is marke other treumatic		Kathleen Lohman/W				venue, #4		thersburg, N	
9	m O		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Re	cen	netery, crer Segome 1	sition (Name of natory or other place	ce) Apr	Date 11	20c. Location - City or T	own, State
Baltimore,			' 4 □ Donation 5 □ Other (Specify)	Cron	nn+02-	lim Tno	! 28,	2005	Bethesda,	Maryland
3all	permit. Departimporti		21. Signature of Formal Service Licers	Ž	RO	Name and Addre	ss of Facility RC	bert A. West Mo	Pumphrey Funtgomery Av -2805	ineral Home,
_	40 E 9 9		/ Varie:							
}	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	Do not ent	er the mode of dyir	ng, such as cardiad	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Examiner			Due to (or as a conseque	ince of):					
		ē	Sequentially list conditions, b.	Due to (or as a consequa	nea off:					
7	uted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury							
	be executed sician and burial-transit	Xal	that initiated events c. resulting in death) Last	Due to (or as a conseque	nce of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	call	d							
89	fficate p phys	Pa	0.							
Вох	death certifica attending pt of or use as the	M	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnance		3-			23d. Date of deliv	rery
ă	death a atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal d 4 Pregnant at time of dea		Ectopic pregnancy Other (specify)	/		Month	Day Year
0	at the de by the a tached	hys	9 Unknown	9□ Unknown						
۵.	res tha igned l be det	by P	Part II. Other significant conditions con	nbuting to death but not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to t	the cause of death?
Records,	v require been sig should b		Chronicalu	ve peterel	læli	M, Kfor	repares	10 Y	es 2⊡No 3□Pro	bably 4 Unknown
000	law re	Completed	Dysphagin,	actie va	luc	Lison	dis	24a. Was	an 24b. Were auto	opsy findings available
æ	The lavate has	lwo	1 Love tone	in Corphana	0 /	111111	let	autop perfor	med? death?	ompletion of cause of 2□ No
Vital		a	25. W s case referred to medical	11 - 21 - 22	· CCC	o c cerna	26. Place of Dea	th (Check only or		2 140
>	ysici is cer direc	0.0	examiner?	ospital:	R/Outpatier	it 3□ DOA Oth			ence 6 Other (Speci	(fv)
o	g Ph er thi	i i	27. Mann of Death		8b. Time o				ow injury occurred	,,
io	ath. r: After e funer	atlo	1 Accident 5 Pending investigation	(WORLI, Day 16al)	Injury		Yes 2 □ No			
Division	or Attending Physicien: Ifter death. Director: After this certifici	ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office	- 1/1	28f. Location (S City or Tow	treet and Number or Run	al Route Number,
Ö	s after de bill Direct	Certification:	4 - Homolas	building, stc. (apacity)				Only or You	ri, Giato)	
	Hospitel 14 hours a Funerel i tely filled		29a. Certifier 1 Certifying Phys	ician: To the best of my know	ledge, deat	occurred at the time	me, date and place	, and due to the	ause(s) and manner as	stated.
	To the Hospitel or / within 24 hours after To the Funerel Dire completely filled in b	Medical	(Check only 2 Medical Examin	er: On the basis of examination and manner stated.	m and/or in	vestigation, in my o	pinion, death occu	Head at the time, t	sate and place, and due t	o me cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		/	29c. Licens			29d. Date signed (Month,	Day, Year)
)	. 1		1 Kenut &	uselle	de	100	4115	/	4/1/23	5/2005
	1041	V	30. Name and address of person who con	npleted cause of death (Item 2	(Type,	Print)	-10		*	
	10		H. Robert Birschb			ell Aven	ue, Gaith	ersburg	Maryland	20877-2801
	Sta Regist		31. Date filed (Month, Day, Year)	32 degistrar's Signatu	2 As	and I				

			For State Registrar	(	State	of Marylan		artment of H			iene eg. No.		
	494 to 1	ğe.	1. Decedent's Name (First, Mid	dle, Last)						2. Date of Deal	h Day 2	Year	3. Time of Death
	Physicia /Medic		MILDRED	OLI	VIA.	MURRAY				April		005	7:40 p M
	Examin	de	4a. Facility Name (If not institut	ion, give str	eet and nu	ımber)		4b. City, Town, o	r Location of Deat	n	4c. County	y of Death	
			MARINER HEALT	'H OF	FORES	ST HILL		FORES				FORD	
	Funeral		5. Social Security Number	6. Sex	v 2.1X F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year)		place (State or Foreign htry)
	Director		220-05-4359		VI 212X1	8	2 Yrs.			June 8	1922	MAR	YLAND
	pur *	1	Usual Residence of Decedent  10a. State 10b. Coun	ity		10c. Cit	y, Town or Lo	cation				1	Od. Inside City Limits
	sho	2						1 00000					1 ☐ Yes 2 ☒ No
	with the Maryland a or 28a-f show the notified at	ect	MARYLAND HA  10e. Street and Number	ARFORD	0 00		HAVRE	deGRACE 10f. Zip Code		1	0g. Citizen of	What Cour	ntry?
	with	ā		ND TXIES				210	70		U.S	7\	
	hours after death with the Marylar lural, or Items 23a or 28a-f show al Examiner must be notified at	Funeral Director	1235 BATTER I		. Was Dec	cedent Ever in U.	.S. 13.	Was Decedent of H		pecify Yes or No-	14. Ra	ce - Americ	
10	fter of ritter	돌	1 ☐ Never Married 2 ☐ M	arried	Armed F 1 ☐ Yes	2 No				to Hican, etc.)	1	ick, White,	
036	urs a	by	3 Widowed 4 □ Divorc	ed	If Yes, G Year or	live Dates:		1⊡Yes 2 <b>XX</b> No	Specify:		Speci	<sup>fy:</sup> BLAC	K
21215-0036	72 hours "natural", idical Ex	ted	15. Deced (Specify only hig.	ent's Educa	ation	n	(Give	dent's Usual Occup kind of work done	during most of wo	rkina	16b. Kind of E	Business/In	dustry
21	within 72 ene. than "na	npie	Elementary/Secondary (0-12			(1-4or 5+)	life.	DO NOT use retired	d)				
21	filed wi Hygien other th	Completed	12th grade				HOUSE	KEEPING	40 14-15-4-11-				ORIAL HOSP.
pu	d oth	Be	17. Father's Name (First, Midd	e, Last)					18. Mothers Na	me (First, Middle,	Maiden Sumai	me)	
yla	2 should be filed with and Mental Hygiene is marked other than aumatic avent, the	၉	GEORGE DORSE							CEVIS	- T		0.4.1
Maryland	2 sh and Is m		19a. Informant's Name/Relation					ng Address (Street					
	s 1 and 2 should be filed within 72 hc of Health and Mental Hygiene. Item 27 is marked other than "nature other traumatic avent, Itta Musical		Shirley Murray	/ Rums	sey/Da			Brant Ct	., Havre		20c. Location		
altimore,	Pages 1 nent of H nnt: If Ite ury or ot		20a. Method of Disposition 1 □XBurial 2 □ Crematic	ın 3⊟Re	moval fron		semetery, cre	matory or other pla	1		200. Location	Oity of 10	ywn, otato
Ë	permit. Pages Department of I Importent: If Ite any injury or of		*4 □Donation 5 □Other			BE		CEMETERY		28-05	DARLIN	GTON,	MARYLAND
Ball	permit Departiment Importent Importent Importent		21. Signature of Funeral Servi	ce Licensee	/		TA	2. Name and Addre	N COMMIIN	ITY FUNER	RAL HOM	E-HAR	FORD, P.A.
	20 ± € 0		Darvaru	· C /	18			21 S PHI				N, MD	Approximate
97			23a Part 1. Enter the disease shock, or heart failure. 1	ist only one	cause on	each line.	n. Do not en	ter the mode of dyli	ng, such as cardia	c or respiratory arr	<b>6</b> 51,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a.		aily.	2 10	thriv	e			1	Ew week
19	/Medical Examiner		resulting in death)		Due to	o (or as a consec	uence of):	)	l			,	
	LAGITITIO		Sequentially list conditions, if any, leading to immediate	b.		e Deve	TUBERCO Of): Y	Isphaq	16	-			
2./	be sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	Due	O (OI as a COIISed	querice or). /	)					
V	and I-tran	Examiner	that initiated events resulting in death) Last	c.	Due to	o (or as a consec	uence of):						
760,	ate be executed hysician and the burial-transit	ical E				- (	,,						
	cate physic			d.									
×	The law requires that the death certifica tte has been signed by the attending phoage 2 should be detached for use as it	by Physician/Med	IF FEMALE:	23	c. If ves. o	outcome of pregna	ancy				23d. D	ate of deliv	erv
BOX	atten for u	ian	23b. Was decedent pregnant in the past 12 months?		1 Live	birth 2 Feta	al death 3[	□Ectopic pregnanc □ Other (specify) _	у		1	lonth	Day Year
20	that the de ed by the detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unk								
120	that the ed by detac	된	Part II. Other significant cond	itions cont	ributing to	death but not res	sulting in the t	inderlying cause giv	ven in Part I.	23e. Did to	bacco use cor	ntribute to t	he cause of death?
ds,	signed of the details	9	5012010	P	ink	in San	c D	h corce		1 🗆 Y	es 2 No	3 ☐ Prol	oably 4 Unknown
	w requir been si should	Completed		10	- (		Y Y	- / 1		24a. Was	an 24b	. Were auto	opsy findings available
3e	has has	E D	-CELLON	0 V 0	1251	Mart	-AGC	dent		autop perfor	sy med2	prior to co death?	impletion of cause of
	Th: Th		Dabet	25_	Tle	llutu	5	ype y	00 Di		20 No	1 🗆 Yes	2□N0
€ € Vital	Physicien: r this certificatal director,	Be	25. Was case referred to mee examiner?		ospital:	71	3500 to the	Ott	nor /	ath (Check only or	ence 6 □Ot	har (Speci	6.1
\$ 5	Phys	- L	1 Yes 2 No			☐ Inpatient 2 ☐ te of Injury onth, Day Year)	ER/Outpatie		ry at	28d. Describe h			
- F	ding h. Afte fune	tion	1 atural 5 ☐ Per 2 ☐ Accident inve	nding estigation	(Mo	onth, Day Year)	Injury		rk? ]Yes 2 □ No				
Mila Division	Attending r death. ector: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be empiried	28e. Pla	ce of Injury - At h	nome, farm, st	reet, factory, office		28f. Location (S	treet and Num	ber or Run	al Route Number,
S. S.	l or A after Dire	erti	4  Homicide	Silvinou	bui	lding, etc. (Speci	fy)			City or Tow	m, State)		
	To the Hospital or Attending Physicien: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier	fying Physical Examin	er: On the	basis of examina	owledge, dea ation and/or ii	th occurred at the travestigation, in my	me, date and plac opinion, death occ	e, and due to the ourred at the time, o	cause(s) and n	nanner as s , and due t	stated. o the cause(s)
	the H the F the F	Medi	one)		and ma	anner stat d.		29c. Licen:			29d. Date sign		
	To To	2	29b. Signature and title of cer	ru ( <del>a</del> )	1 m	11	-20	250. Licens				(mornil)	
			1 (11 Ca	m	1	W.		VI	9583	, 1	toril	25	2005
	<i>i</i> -		30. Name and address of per-	son who cor	mpleted ca	use of death (Ite	m 23a) (Type	Print)		SLav	STV	ee!	21091
	4		31. Date filed (Month, Day, Y	UNE	32	egistrar's Sign	ature	THU	MY	Abe	reer	116	ryland
	St	ate	APR 3	Q 200	5	. Jogistiai S Sign	to d	12.18.					/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24<sup>Day</sup> 2005ar Month ()4 **Physician** Albert Debs McIntyre 06:05am /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 → M 2 □ F 216-01-4896 90 Yrs. Pennsylvania 08-02-1914 Director Usual Residence of Decedent Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28e-f show treumatic event, the Medical Examinar must be notified at Silver Spring 1 ☐ Yes 2 ☐ Yo Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 20901 9003 Glenville Rd. IISA items 23a death Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Importent: If Itiem 27 ie marked other than "nature!" ..." any injury or other treumatic event. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 0 14. Race - American Indian, Black, White, etc. 1341 Yes 2 2 □ No 1 ☐ Never Married 2 X Married White 1 ☐ Yes 2 X No Specify: Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dental Technician Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Claude D. McIntyre Anna Mae Fazenbaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9003 Glenville Rd. Silver Spring MD 20901 Eleanor McIntyre (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 04-28-2005 Chesapeake Crematory Beltsville MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Rapp Funeral & Cremation Service 21. Signature of Funeral Service 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Ave Silver Spring MD 20910 Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Acute Tubular Necrosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury Due to (or as a consequence of): Examiner 10 Days The law requires that the death certificate be executed the burial-transit Dehydration that initiated events resulting in death) Last Due to (or as a consequence of): iding physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown Anemia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No H/O Colectomy & Diarrhea 24a. Was an 1 ☐ Yes 2 🔯 No Division of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 9 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide hours after To the Hospitel o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kshama 04-26-2005 D60826

Registrar DHMH 17 Rev 1/200

State

Box 68760.

P.O.

Kshama Garg 1500 Forest Glen Rd. Silver Spring MD 20910

Mener

32. Registra Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APR 2 9 2005

31. Date filed (Month, Day, Year)

	,	1 - For State Registrar	State of Maryland / I	Department of Health and Certificate of Death	Mental Hygie	2000	9.8
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last  Helen  4a. Facility Name (If not institution, give	Parie Mulli	4b. City, Town, or Location of Deal	2. Date of Death Month	Day Year 3. Time of Death 27 2005 1.00 A.	M
Funeral Director	lei	3032 Tiffan / 5. Social Security Number 9. Se 408-34-8787	TERRACE	Forest Hill	8. Date of Birth	HARFORD  9. Birthplace (State or Fore Country)  Ten NESSER	nign
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Importent: if item 27 is marked other than "natural, or items 23a or 28e-1 show any injury or other treumatic event, the Wedical Exam natural be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  10e. Street and Number  1253  11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced  15. Decedent's Ed.  (Specify only highest grace  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  19a. Informant's Name/Relationship (7)  10mme Houck  20a. Method of Disposition  1 Burial 2 Cremation 3 Differ (Specify, 2)  21. Signature of Funeral Service Licenses	College (1-4or 5+)  No. 1999  Appe, Print)  - Daughter  20b. Place of comments  Comments  Comments  Comments	10. Zip Code  10. Zip Code  3. Tule  13. Was Decedent of Hispanic Origin? (s If Yes, specify Cuban, Mexican, Puer  1 Yes 2. No Specify:  1. Decedent's Usual Occupation (Give kind of work done during most of wo	Specify Yes or No- no Rican, etc.)  The specific of the specif	ty or Town, State, Zip Code)  HII MD 21050  Location - City or Town, State  11195 PORT	
icate be executed Wedical Examiner Sphysician and Sphysician and Sphysician and Sphysician and Sphysician Sphy	dical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or conductor resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or when your cause)	ilications that caused the leath. Do one pause on each line.  a	not enter the mode of dying, such as cardial for the local kins of a constant of the local kins of a constant of the local kins of the loc	c or respiratory arrest,	Approximate Interval Between Onset and Death H must l	rs .
Is, P.O. Box 6i res that the death certific igned by the attending p be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	h 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year	
v requir	Completed by Ph	Part II. Other significant conditions co	1	in the underlying cause given in Part I.	1 ☐ Yes  24a. Was an autopsy perform d	2 No 3 Probably 4 Unknow 24b. Were autopsy findings availal prior to completion of cause of death?	wn
Division of Vital Records, To the Hospital or Attending Physicien: The law requires t within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be	Certification; To Be Co	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3  Suicide 4 Homicide 6 Could not be determined	(Month, Day Year)	Other: 4   Nursing	ath (Check only one) Home 5 Residence 28d. Describe how in	e 6 KOther (Specify)	શ :5
The Hospital in 24 hours a the Funeral I pletely filled	Medical Ce	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	vsicien: To the best of my knowledginer: On the basis of examination a and manner stated.	je, death occurred at the time, date and plac nd/or investigation, in my opinion, death occ	urred at the time, date	and place, and due to the cause(s)	- 1
Tot with Com	Z	29b. Signature and title of certifier  30. Name and address of person who certifier	completed cause of death (Item 23a)		3 0	Date signed (Month, Day, Year) 4-27-05	
St Regist	7	31. Date filed (Month, Day, Year)	32. Registrar's Signature	JOHAS HOPKINS O	NEOCOSY Ballino	1650 Orleans St R MD 21231	

05-2875 B.K.S EDWARD MILLER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of	Maryland / Depa	artment of H		l Mental Hy	0000	t t mm m a
			Decedent's Name (First, Middle	e, Last)		timouto or		2. Date of De		3. Time of Death
	Physici		Edward Miller					APRIL :	25, Day 2005 Yeer	1405 P M
	/Medic Examir		4a. Facility Name (If not institution	, give street and numb	er)	4b. City, Town, o	r Location of De		4c. County of De	ath
		•	UPPER CHESAPE	AKE MEDICAI	CENTER	BEL A	AIR		HARFORD	
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H Hours Mi		rth 9. Bi	irthplace (State or Foreign Country)
	Director		218-68-6847 Usuel Residence of Decedent	ISM 2LF	49 Yrs.				3/1955 MD	
	land		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary First	ţo	MD Harfo	rd	Edgewood					1 ☐ Yes 2 ☑ No
	h the	irec	10e. Street and Number	14	Lagewood	10f. Zip Code			10g. Citizen of What C	Country?
	th wil	alD	1916 Harbinger	Trail		21040			United Sta	ates
	r dea	Inel	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S. 13.	Was Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	14. Race - Am Black, Wh	
36	s afte	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	ied 1 Tes 2 If Yes, Give Year or Date		1 ☐ Yes 2 ☑ No	Specify:		Specify:	
21215-0036	72 hours after death with the Maryland naturel', or liems 23a or 28a-f show liteal Enatimer must be meilliad at	ed	15. Deceden			dent's Usual Occup	pation		16b. Kind of Busines	ite s/Industry
215	hin 72	Completed	(Specify only higher	completed) College (1-4	life	kind of work done DO NOT use retire	during most of w d)	vorking	Landscapin	,
21	gd with	Com	9	ounege (1 4	Lawn	Care				
pu	be file tal Hy d oth event	Be (	17. Father's Name (First, Middle,	Last)			18. Mother's N	lame (First, Middle	, Maiden Surname)	
yla	Men Men Marke Marke	ပ္	Leland Louis Co					ne Franci:		
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23s or 28s-1 show other treumatic event, the Medical Examinar must be rediffed at		19a. Informant's Name/Relations						er, City or Town, State,	,,
	1 and Healt em 2		Patricia Gullio 20a. Method of Disposition	n/Sister	20b. Place of Dispo	sition (Name of		Edgewood Date	d, MD 21040 20c. Location - City o	
nor	ages ant of tt: If it		1 Burial 2 Cremation 4 Donation 5 Other (S		ate cemetery, cre	matory or other pla	1	Apr 27	ŕ	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items any injury or other treumatic event, the Medical Erain naturing once.		21. Signature of Funeral Service			ke Cremat 2. Name and Addre		. 2005	Beltsville	, Maryland
ä	Depar Impor any in		He	lell -				ral Alter		Maryland 21286
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	sed the death. Do not ent	er the mode of dyir	ng, such as card	iac or respiratory a	rrest,	Approximate Interval Between
. U	Paysician		Immediate Cause (Final disease or condition	Ath	wsclerotic	Cardi	Vascula	ar 180	ESC	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):					
	Lxammer	ē	Şequentialiy ilst conditions,	B. Bus to /or	as a consequence of):					
	ted nsit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua 10 (01	as a consequence or):					
·	and al-tra	Examin	that initiated events resulting in death) Last	c Due to (or	as a consequence of):					
68760,	icate be executed physician and s the burial-transit	dical		d						
-		a l	15 551111 5							
Вох	death certific e attending p d for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco 1 ☐ Live birth		Ectopic pregnancy	,		23d. Date of de	,
	ne dea the at hed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnan 9☐ Unknow	t at time of death 5	Other (specify)			Month	Day Year
P.0	a o o a	Phy	Part II. Other significant condition	MS contributing to deal	th but not resulting in the u	nderhina cause an	en in Part I	23a Did t	obacco use contribute	to the cause of death?
ecords,	Se og		Tarri, only organization	one contributing to doc	ar out not resulting in the b	riderlying cause giv	on mir anti.			Probably 4 Unknown
Sor	> 4 77	Completed						24a. Was		utopsy findings available
Re	2 2 2	dwo				_		autor perfo	psy prior to prmed? death?	completion of cause of
Vital		ø	25. Was case referred to medica				26 Place of D	1 X Yes eath (Check only o	2 No 14 Ye	s 2 No
Ϊ	Physicien: this certific ral director,	To B	examiner?  **MXYes 2 \sum No	Hospital: 1   Inp	atient 2X ER/Outpatier	nt 3 DOA Oth	00		dence 6 ☐Other (Spe	ecify)
n of			27. Manner of Death  1 X Natural 5 Pendin	28a. Date of (Month,	Injury 28b. Time o	f 28c. Injur			how injury occurred	.,
siol	Attending r death, ector: After by the fune	catic	2 ☐ Accident investi	gation			Yes 2 □ No			
Division	or Att	Certification:	3 Suicide 6 Could 4 Homicide determ	inad 286. Place of	Injury - At home, farm, str , etc. (Specify)	reet, factory, office		28f. Location (3 City or Tox	Street and Number or F wn, State)	Rural Route Number,
	Hospital	င်	29a. Certifier 1 Certifyir	a Physician To the h	ant of my knowledge deal					
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical		Examiner: On the basi and manner	est of my knowledge, deat is of examination and/or in r stated.	n occurred at the tir vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	date and place, and du	is stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie		4 2	29c. Licens	e number		29d. Date signed (Mon	ith, Day, Year)
	,		> 70 las	11/0/3	45-	00	ME		APRIL 25,	2005
-	n		30. Name and address of person	who completed cause	of death (Item 23a) (Type,	Print)				
			CABILICCE	444	Ci	111 Penn	Street	Baltimo	ore, Maryla	nd 21201
	Sta		31. Date filed (Month, Day, Year)	32. Reg	istrays Signature					
	Regist	ar	AP	R 2 9 2005	Blacker S.	1. 19. 19. 19. 19. 19. 19. 19. 19. 19. 1				

	State of Mary	and / Department of Health and Mo	
	1- For State State Registrar	Certificate of Death	Reg. No 005 14611
	Decedent's Name (First, Middle, Last)		Date of Death     3. Time of Death
Physician /Medical	GEORGE BERNARD MORRISO	MO	APril- 26-20051:58PM
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Franklin Squase Hospita 5. Social Security Number 6. Sex 7. Age (In	Vrs. Jast birthday) If Under 1 Year If Under 24 Hrs.	Baltimore
Funeral Director	5. Social Security Number 6. Sex 7. Age (In 215-10-3965 12XM 2 F 91	7 11 11 12 13 14 14 14 14 14 14 14 14 14 14 14 14 14	8. Date of Birth (Month, Day, Year) 2-23-1914  9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent		Z-23-1314 PARILIAND
arylan show	10a. State	. City, Town or Location  ROSEDALE	10d. Inside City Limits 1 □ Yes 2 🖾 No
Ba-f secto	10e. Street and Number		
6 ufter death with the Maryland or tema 23a or 28a-f show right must be notified at right must be notified at Funeral Director	1620 WEYBURN ROAD	10f. Zip Code 21237	10g. Citizen of What Country? U.S.A.
ma 23	11. Marital Status 12. Was Decedent Ever	in U.S. 13. Was Decedent of Hispanic Origin? (Spe- If Yes, specify Cuban, Mexican, Puerto F	city Yes or No- 14. Race - American Indian,
after or its	1 Never Married 2 Married 1 Yes, Give	1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)  Black, White, etc.  Specify: WHITE
5-0036 72 hours aft natural; or also Evan	3 Wildowed 4 Divorced Year or Dates:	-	
121215-00 eld within 72 had yet than "natura nt, the Medical Ent.	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of workir life. DO NOT use retired)	g 16b. Kind of Business/Industry
212 212 2 withing Jene.	Elementary/Secondary (0-12) College (1-4or 5+)	WELDER	BETHLEHAM STEEL
/land 2: //land 3: //land	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)
Vian Vian Mentit bearing arked attice	BERNARD MORRISON	ELLEN	(TARLETON)
Baltimore, Maryland 21215-0036  Bernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permittents of Health and Mental Hyglene.  To her constitution of their traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and pince and pince and pince and pince and pince to the permittents.	19a. Informant's Name/Relationship (Type, Print)  CLARA MORRISON/ WIFE	19b. Mailing Address (Street and Number or Rural 1620 WEYBURN ROAD ROS	Route Number, City or Town, State, Zip Code) SEDALE, MD 21237
Baltimore, N Baltimore, N permit. Pages 1 and Department of Healt Important: If the 23 any injury or other 1 pages.		CONTRACTOR STATE OF THE PARTY O	ate 20c. Location - City or Town, State
Baltimore, Benit. Pages 1 a Department of Hee Important: If them any injury or othe	Tabunal 21 Chemation 3 Linemoval from State 1		29-2005 BALTIMORE, MD
mit. F partme	21. Signature of Funeral Service Licensee	22. Name and Address of Facility CVA	CH/ROSEDALE FUNERAL HOME
0	1675	1211 CHESACO AVENUE	ROSEDALE, MD 21237
2 200	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not enter the mode of dying, such as cardiac or	respiratory arrest, Approximate Interval Batween Onset and Death
Physician	Immediate Cause (Final disease or condition resulting in death)	ic bowel	Offset and Death
/Medical Examiner	Due to (or as a con	nsequence of):	
(, )	Sequentially list conditions, if any, leading to immediate b. Due to (or as a condition)	nsequence of):	
executed in and instransit	Sequentially list conditions, if any, leading to immediate cause. Enter Underrying Cause (Disease or injury that initiated events c.		
3760, ate be executed system and he burial-transit	resulting in death) Last Due to (or as a con	nsequence of):	
8760 rate be e hysician the burie	d.		
P.O. Box 68' nat the death certificated by the attending phy letached for use as the Physician/Medic	IF FEMALE: 23c. If yes, outcome of pr	egnancy	23d. Date of delivery
Bo leath atten affor u	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 1	Fetal death 3 ☐ Ectopic pregnancy	Month Day Year
.O. tithe c by the achec	9 Unknown 9 Unknown		
cords, P.O. Box w requires that the death cer been signed by the attendir should be detached for use leted by Physician/N	Part II. Other significant conditions contributing to death but no	t resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
ord equir sen si tould			1 Yes 2 No 3 Probably 4 Unknown
al Record  The law requit cate has been s page 2 should			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
al H			1 Yes 2 No 1 Yes 2 No
Vital Rec	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient	26. Place of Death 2 ER/Outpatient 3 DOA Other. 4 Nursing Hon	(Check only one)  ne 5 ☐ Residence 6 ☐ Other (Specify)
Division of Vital Records, P.O. Box 68 tor Attending Physician: The law requires that the death certifical after death.  In by the funeral director, page 2 should be detached for use as the ertification; To Be Completed by Physician/Mediertification; To Be Completed by Physician/Medie	27. Manner of Death 28a. Date of Injury	28b. Time of 28c. Injury at 2	8d. Describe how injury occurred
sion arb. or: Aft atto	2 Accident investigation	M 1 Yes 2 No	
Division C train or Attending P rs after death. rall Director: After t led in by the funera Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (S)		8f. Location (Street and Number or Rural Route Number, City or Town, State)
pital c	29a. Certifier Certifying Physician: To the best of my	knowledge, death occurred at the time, date and place, a	ad due to the eques(s) and manner so stated
the Hosp thin 24 hou the Funer mpletely fil	(Check only one)  2 Medical Examiner: On the basis of examiner on the basis of examiner and manner stated.	mination and/or investigation, in my opinion, death occurre	d at the time, date and place, and due to the cause(s)
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2 should be detached for use as the more after this certification; To Be Completed by Physician/Medi	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	1 Head M	Respond	04-26-05
4	30. Name and address of person who completed cause of death	(Item 23a) (Type, Print)	0 11
617	31. Date filed (Month, Day, Year) 32 Agistrar's	) Flanhlin Square Prive	04-26-05 e Baltimore, MD. 21237
State Registrar	31. Date filed (Month, Day, Year) APR 2 9 2005	15 House	

			S 1 - State Registrar	tate of Maryland / [	Depai		ealth and			005	14601			
	Physici		1. Decedent's Name (First, Middle, Last)	Mooney				2. Date of De Month	Day	Year	3. Time of Death			
	/Medio Examin		4a. Facility Name (If not institution, give stre			4b. City, Town, or	Location of De		4c. (	County of Death				
			Howard County Hosp	ital		Columb	ia		Hov	vard				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. (Mor							e of Birth north, Day, Year)  y 8,1941  Maryland  9. Birthplace (State or Foreign Country)  Maryland				
	yland sow		10a. State 10b. County	10c. City, Tow	n or Loc	ation					10d. Inside City Limits			
	B-fst	ş	Maryland Howard	E1	lico	tt City					1 ☐ Yes 2 No			
	or 28	Olre	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cou	intry?			
	s 23a	rai	2530 Kensington Ga		40.34	21043		10 - 11 - 11		U.S.A.				
	item item	Funeral Director	11. Marital Status 12.  1 ☐ Never Married 2 ☒ Married	Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ⊠ No	13. W	Yes, specify Cuba	n, Mexican, Pu	(Specify Yes or Ne erto Rican, etc.)	)-   1	<ol> <li>Race - Ameri Black, White</li> </ol>				
036	al', or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	11	☐ Yes 2☑ No	Specify:		,	Specify: W	hite			
2-0	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f show the Medical Examinat must be nutified at	Completed	15. Decedent's Educati (Specify only highest grade co		. Decede	ent's Usual Occupa ind of work done of O NOT use retired	ation during most of v	working	16b. Kin	d of Business/Ir	ndustry			
121	within ne. han	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)			)		m 1					
d 2	e filed within at Hygiene. I other than vent, the Me	ပိ	17. Father's Name (First, Middle, Last)	4 E	ngin	leer	18. Mother's N	lame (First, Middle			ications			
lan	Id be ental ked o	To Be	Elmer P. Mooney				Carlyn		,	,				
Maryland 21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan narment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examples must be nutified at a.		19a. Informant's Name/Relationship (Type,	Print) 19b	. Mailing	Address (Street a		Rural Route Numb	er, City or	Town, State, Zi	p Code)			
-	and 2 salth a n 27 i		JoAnn Mooney (Wife		-				Ellic	cott Cit	y, MD 21043			
Baltimore,	of He if iten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem	20b. Place o cemete.	f Dispos	ition (Name of atory or other plac	9)	Date	20c. Loc	ation - City or T	own, State			
ţ	t. Pag tment tant: ijury o		* 4 ☐ Donation 5 ☐ Other (Specify)			s Cemete:					ty, Maryland			
Ba	permit. Pages 1. Department of He Important: if iten any injury or oth once.		21. Signature of Funeral Service Licensee	1	Wi 163	tzke Fur O Edmond	ss of Facility neral Ho Ison Ave	ome of Ca	tonsv	ville, l e, Maryl	Inc. land 21228			
1760,	/Medical Examiner who be considered with the burial-transit who be considered to the constant of the burial-transit with the burial-transit with the burial-transit with the constant of the c	cai Examiner	cai Examiner	icai Examiner	cai Examiner	shock, or heart failure. List only one of limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. List John of Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence  Due to (or as a consequence  Due to (or as a consequence	of).	ephenus					Interval Between onset and Death Tyeur
O. Box 68	death certific e attending pi d for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ictopic pregnancy Other (specify)				23d. Date of delivery Month Day Year						
s, P.	signed be de	by	Part II. Other significant conditions contril	outing to death but not resulting i	in the un	derlying cause give	en in Part I.				the cause of death?			
Record		Completed						24a. Was auto perf 1 \square Yes		24b. Were aut prior to co death? 1 \( \subseteq \text{Yes}	opsy findings available ompletion of cause of			
Vital	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	- Mal				Death (Check only	one)					
of	this all dill	2	1 Yes 2 No Hos	1 primpatient 2 EH/O	-		4 ( 14015111	g Home 5 Res			ify)			
	Jing After fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		a of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Work?  M 1 □ Yes 2 □ No									
Division	l or Attending after death. Director: After sin by the fune	Certification;	a Could not be	28e. Place of Injury - At home, fa building, etc. (Specify)	am, stre				l Number or Au	al Route Number,				
	To the Hospital c within 24 hours af To the Funeral D completely filled in	Medical Co	29a. Certifier 1 Certifying Physic (Check only one)	an: To the best of my knowledg: On the basis of examination ar and manner stated.	e, death nd/or inv	occurred at the timestigation, in my o	ne, date and pli pinion, death o	ace, and due to the ccurred at the time	cause(s) date and	and manner as place, and due	stated. to the cause(s)			
	ro the within ro the complex	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date	signed (Month	, Day, Year)			
			> Yhich he led the	lula nos		D3	8 <i>8500</i>		An	1/25	2055			
	6		30. Name and address of person who com	pleted cause of death (Item 23a)  IN TIPE LIGHTS IN 18  2005 Register's Signature	(Type, F	Print). Li YYle	Parcix	ent Ph	Cole	une pur	mD21044			
	St Regist	ate rar	31. Date filed (Month, Day, APR 2 9	2005 Registar's Signature	B.	parte								

Amend Item/5, per FH; 6943, 5/16/05, CC State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 Year April 26, **Physician** 5:10 рм Alan Edward Morse, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Timonium If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | April 11, 1944 5. S220 S40 it 1794per 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Mass. 1 M 2 □ F Yrs. 61 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or 28e-f show other traumatic event, the Medical Exandrer must be notified at 1 ☐ Yes 2 ☐ No Director Harford Forest Hill Md. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21050 334 Streett Circle or Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2≦ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married white 21215-0036 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced \*neturel'. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) and Mental Hygiene. Is marked other then Elementary/Secondary (0-12) engineer dredging Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be es 1 and 2 should be fi of Health and Mental H fitem 27 Is marked ott Hazel Loud Alan E. Morse, Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 334 Streett Circle, Forest Hill, Md. 21050 Patricia Morse/wife Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of Heart: If ite ö 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 4/28/2005 Bayview Crematory Baltimore, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MELANOMA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, the attending physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for Month in the past 12 months? Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{X} \) Other (Specify) \( \text{HOSPICE} \) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 X No Certification: To this 28a. Date of Injury (Month, Day Year) s after death. 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide

Division of Vital Records, P.O.

ALAN MORSE

2005

completely

within 24 hours a To the Funerel D

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARTQ MAHMOOD 31. Date filed (Month, Day, Year)

APR 2 9 2005

4 Homicide

29b. Signature and title of certifier

29a. Certifier

determined

12

and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

725

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

		State Registrar		Ce	rtificate of	Death		g. No. O	y % 1994	1 1 10 10
Physicia		1. Decedent's Name (First, Middle, Last					2. Date of Death Month	h 💪 🔾	Year	3. Time of Death
/Medica	al .	HMCM William		cDermott (			April 20	6, 2005		3:10 A M
Examine	r	4a. Facility Name (If not institution, give			4b. City, Town, or Location of Death 4c. County of I					
		Stella Maris Hos  5. Social Security Number 6. Se	-	e (In yrs. last birthday)	Timoni		8. Date of Birth	Ba	1tim	
Funeral Director			<b>X</b> M 2□ F	77 Yrs.	Months Days	Hours Min.	Month, Day, June 14,			lace (State or Foreign try) York
a field within 7.2 hours are dean with the Maryano half Hygiene.  so other than "natural", or Items 23a or 28a-1 show event, Itte Medical Examination in the routiled at	5	10a. State 10b. County	_	10c. City, Town or Lo	ocation				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
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No e	۵	113 Chell Road			10f. Zip Code	005		og. Citizen of W		uy:
ns 23	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S. 13.		.085 lispanic Origin? (Sp	ecify Yes or No-		SA - Americ	an Indian.
riten	들	1 Never Married 2 Married	Armed Forces? 1 ⊠Yes 2 ☐ If Yes, Give	No		lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black	k, White,	etc.
0 10	2	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:		Mhite
natur	Completed	15. Decedent's Edu (Specify only highest grad	acation	16a. Dece	dent's Usual Occup	ation during most of work	rina	16b. Kind of Bu	<u>`</u>	
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and Mental Hyglene. Is marked other than aumatic event, Itu M.	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam			θ)	
and Mental s marked o umatic eve	င္	George (unk) McD		40h 14-70			(unk) Fox		O	
If Item 27 Is marke or other traumatic	И	19a, Informant's Name/Relationship (T)		.0A		and Number or Rur		City or Town, 3	State, ∠ip	Code)
Health tem 27 other tra		Gail O'Keefe/ Daug 20a, Method of Disposition	gnter	20b. Place of Dispo	Mandarin	Court, E	ldgewood. Date 2	MD 210 20c. Location - 0	040 City or To	wn State
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Department of I important: If Ite any injury or ot once.		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licens</li> </ul>							con,	Virginia
any ir		Itali Call	Vila	T	McComas F	s of Facility uneral Ho	me, P.A.		,	1 01000
		23a. Part1. Enter the disease, or comp	lications that caused			sbury Roa			aryıa	Approximate
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne Lause on each li			9,	ar respiratory and			Interval Between Onset and Death
rsician ledical	1	disease or condition resulting in death)	a		CER				-	
aminer			Due to (or as	a consequence of):						
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ig phy as th	ed									
endir r use	Physician/Medical	230. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy	,		I	of delive	,
the att	SIC	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a 9□ Unknown		Other (specify)	·		Mon	ith	Day Year
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signed I	by	Part II. Other significant conditions co	intributing to death b	out not resulting in the u	nderlying cause giv	en in Part I.				e cause of death?
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as be	Completed by						24a. Was an autopsy	v   D	ere autor	osy findings available inpletion of cause of
page	Son						perform	ned? d	eath?	2 No
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0 0	٥	1 105 2 140	Hospital: 1 ☐ Inpatio		nt 3 DOA Oth	er: 4 🗆 Nursing Ho	me 5 Reside			HOSPICE
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tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No	00(1) (0)			
Olrec in by	Certification:	4 Homicide determined	286. Place of in	jury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office		28f. Location (Str City or Town		er or Rura	Houte Number,
Funeral Director:		29a. Certifier   Certifying Phy	reinian. To the best	of mu knowledge deat	h		and due to the co			
within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medicai	(Check only one)	iner: On the basis of and manner st	of my knowledge, deat of examination and/or in ated.	n occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	red at the time, da	ite and place, a	nd due to	the cause(s)
within 24 hours after To the Funeral Director completely filled in I	Σ	29b. Signature and title of certifier			29c. Licens	e number	29	Date signed	(Month, I	Day, Year)
			_			12163		7100	100	
N		30. Name and address of person who c	ompleted cause of	death (Item 23a) (Type,	Print)					D 21093

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** June Texas Matusiak 11:30 P.M April 27 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 334 Cresswell Road Baltimore Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 10,1918 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months 1 M 2 XF Director <u>218 22 7660</u> 87 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinar must key aditive at 1 ☐ Yes 2 ☐ No Director Baltimore Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 21225 334 Cresswell Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after Affiled Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry . Hygiene. Elementary/Secondary (0-12) 3rd College (1-4or 5+) Own Home Homemaker Pages 1 and 2 should be filed nent of Health and Mental Hygi ant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (not available) (not available) ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Gracie / Daughter 334 Cresswell Road Baltimore, Maryland 21225 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland ¹ 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 4/30/2005 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. namucam 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YPERLTENSION Physician 104 EM disease or condition resulting in death) /Medical to (or as a consequence of): Examiner DISENTE Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) hе 9 Unknown 3 signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Yes Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 TYes 2 1 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)
28d. escribe how injury occurred Jo 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? After Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No М death. investigation Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Testifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the dause(s) and mainer as succes.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 37111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOGHAMMONDS LA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 9 2005 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Deal Year **Physician** BARRY MICHAEL 1.00 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDER ORCHARD BEAC 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 3 Days Hours Min 226:76.238 5 Yrs. Director -21-51 NEWJERSEY Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits rai", or items 23a or 28e-1 shov Examiner must be nutified at 1 ☐ Yes 2 No Director HARD BEA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. nent of Health and Mental Hygiene. nent if item 27 is marked other than "natural; or items 23a or ; ury or othar treumalic event, the Madical Examinator must be any J.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Specify: 4 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: MITE 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ONSTRUCTION 4BORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DANIEL JUSEPH C 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) MD.ZIZZE 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. BAYVIEW CAEMATORY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Fuyery Service Licensee 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 233. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) to Cardia Ph sician /Medical Due to (or as a consequence of **Examiner** weers eron fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by OU stry elin Carrie 1 Yes 2 No 3 Prebably 4 Unknown soliles 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a Was an autopsy 2 No 1 Yes

Sign

Completed ٩ Certification:

Medicai

P Hospital or Attending P 24 hours after death. Funeral Director: After to To the Hospital within 24 hours at To the Funeral D

State

Registrar

31. Date filed (Month, Day, Year) APR 2 9 2005

29b. Signature and title of certifier

25. Was case referred to medical

5 Pending

investigation 6 Could not be determined

1 Yes 2 DNO

examiner'

1 tural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Allendry Docter

28a. Date of Injury (Month, Day Year)

1 Inpatient 2 ER/Outpatient

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Destitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D21684

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Pesidence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C.V. CYRIAC. 19.D. BOZI RITCHUZ LOWY, PASADENA, V. CYRIAC.19.D

32. Paistrar's Signature

3 DOA

28c. Injury at Work?

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 **Physician** Gloria Lenzi Okulski April 26, 5:15P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11136 Hurdle Hill Drive Potomac Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) | Jan. 2, 19 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🗓 F 72 Director 105-26-7268 1933 New York Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Evantrer must be notified at 1 ☐ Yes 2 No Be Completed by Funeral Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11136 Hurdle Hill Drive 20854 United States ss 1 and 2 should be filed within 72 hours after death of Health and Mentaf Hyglene. Ifem 27 is marked other than "natural", or items 23, other traumatic event, If a Model Exactle at rausal. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status l □ Yes 2 ☑ No f Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specity: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Lenzi Deleanda Bandini Pages 1 and 2 should 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health : Liberty A. Okulski/Daughter 11136 Hurdle Hill Drive, Potomac, Maryland 20854 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Montgomery or other place) April 29, t ☐ Burial 2 In Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Bethesda, Maryland 2005 Crematorium, Inc. 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Chase. Inc. 21. Signature of Funeral Servide Licensee Chase, Ir 0814-3501 M00198 7557 Wisconsin Ave., Bethesda, MD 20814-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Metastatic Ovarian Carcinoma 4 3/4 Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Juisease or injury that initiated events Examiner Due to (or as a consequence of) use as the burial-transit to the Hospital or Attanding Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 X No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 □ No 1 Yes 2X No 1 Tyes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending death. investigation M 1 ☐ Yes 2 ☐ No the f 2 Accident after death 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 T Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D07285 mes Wil April 27, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O P 9707 Medical Center Drive #300, Rockville, Maryland 20850 James A. Brown, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** April 27 Day 2005 Pear 6:25 PM Pinetti /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 18, 1941 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours 122-32-3813 1 ☐ M 2 □ ▼F 63 New York Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itams 23a or 28a-f show the Medical Expressional be notified at 1 X Yes 2 □ No Completed by Funeral Director MD Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20855 7405 Mill Run Drive USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than "natural", or Itams 23a any injury or other treumatic event. The Wedical Exprine Finals once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be August Koerber Marie Cervenka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lou Pinetti - Husband 7405 Mill Run Drive Derwood, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Linden Hill Cemetery 5-2-05 Ridgewood, New York A □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Morton-Ridgewood Chapel 21. Signature of Funeral Service Licensee Mullen 663 Grandview Ave. Ridgewood, NY 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Cancer of Unknown Primary Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated excellents) Due to (or as a consequence of): Examiner ysician and e burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physiclan/Medical the attending phys as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 3 Probably 4 □Unknown 1 Tyes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes X□ No 24a. Was an page 2 autopsy performed? res 2 \( \text{No} \) certificate 1 🗌 Yes Division of Vital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2X No P this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification; After 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funeral Dire Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ro tha 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur and title D35635 April 28, 2005 NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Prince Phillip Dr. Olney, MD 20832 Joseph Kaplan, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No 9   Unknown   9   Unknown   9   Unknown   1   Yes 2   No 9   Unknown   9   Unknown   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3				ricase			ont of Hoolth and A	-	•	
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286. Place of fnjury - At home, farm, street, factory, office  287. Location (Street and Number or Rural Route Number, City or Town, State)  288. Place of fnjury - At home, farm, street, factory, office  286. Location (Street and Number or Rural Route Number, City or Town, State)  288. Place of fnjury - At home, farm, street, factory, office  286. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  29b. Signature and title of certifier (29b. Signature and title of certifier)  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  WCLLS  31. Date filed (Month, Park Park)  32. Registrar's Signature  33. Registrar's Signature	28d. Date of Injury 28b. Time of 28c. Injury at Work?								injury occurred	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 24,2005 **Physician** James Royster Pierce, Jr. 10:30PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3850 Enfield Chase Ct. #117 Bowie Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** XXM 2□F Yrs. 579-50-8977 65 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits item 27 is marked other then "neturel", or items 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3850 Enfield Chase Ct. #117 20716 U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 2 College (1-4or 5+) al Hygiene. Scientific Illustrator Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental I Pages 1 and 2 should be and Menta James Royster Pierce, Sr. Sara Nicholson Brown ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Lunda Sue Pierce (Wife) 3850 Enfield Chase Ct. #117 Bowie, Maryland 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 28. ₽ = 1 N Burial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) ō permit, Page Department of Importent: If any injury or Cedar Hill Cemetery Suitland, Maryland 2005 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lee Funeral Home, Inc. ta M01284 6633 Old Alexandria Ferry Road Clinton, MD20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SING 16months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ N Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has certificate 1 ☐ Yes 27∕∑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) မှ 1 ☐ Yes 2XXVo 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide the Hospital or To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signa D08754 April 27, 2005 of person who completed cause of Bensinger, MD o completed cause of death (Item 23a) (Type, Print) singer, MD 7525 Greenway Center Drive Suite 205 Greenbelt, Maryland Thomas A. 31. Date filed (Month, Day, Year) State Registrar

		1	For Stete Registrar	State of Marylan	-	rtment of H			giene	05 14610
	Physicia /Medic Examin	an al -	1. Decedent's Name (First, Middle, Last  A. Facility Name (If not institution, give		Pe	4b. City, Town, or	Location of De	2. Date of De Month	Day 233	Year 3. Time of Death  You of Death
	Funeral Director	- I	50 05 HOKOS 200 5. Social Security Number 6. S	your Core		If Under 1 Year Months Days	If Under 24 Hi Hours Mi	75. 8. Date of Birn (Month, Da JULY 1	h, Year) 7, 1962	9. Birthplace (State or Foreign Country) MARYLAND
	e Maryland le-1 show	Director	10a. State 10b. County  MD . N/A	10c. Cit	y, Town or Loc					10d. Inside City Limits 1
	with the	i Dire	10e. Street and Number 508 S. NEWKIRK S	TREET		10f. Zip Code	21224		-	What Country? D STATES
5-0036	thin 72 hours after death with the Maryland e. m. "naturel", or items 23e or 28e-f show Medical Exart her must be modified at	by Funerai	11. Marital Status  1) Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 XXVo If Yes, Give Year or Dates:		Vas Decedent of Hi Yes, specify Cuba	Ispanic Origin? In, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)	- 14. Ra Bla Speci	ice - American Indian, ack, White, etc. WHITE
2121	within 72 ene. then "na'	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 10TH	Jucation (de completed) College (1-4or 5+)	(Give	ent's Usual Occupi kind of work done of OO NOT use retired PAINTE	during most of w 1)	vorking		Business/Industry RUCTION
and	uld be filled fental Hygi rked other tic event, I	To Be (	17. Father's Name (First, Middle, Last, JOHN P. PAPPAS					ame (First, Middle, A J. KAL)		me)
Maryland	d 2 shouth and N		19a. Informant's Name/Relationship ( HELEN HALEY/SIS					Rural Route Number		
altimore,	Pages 1 an nent of Heal nnt: if item 2 nry or other		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	lace of Disposemetery, crem	sition (Name of natory or other place	ee)	Date	20c. Location	- City or Town, State
Baltin	permit. Pag Department Importent: it any injury o		4 □ Donation 5 □ Other (Specification of Funeral Service Liceration	22		ss of Facility		. ZEILE	ORE, MARYLAND R & SON, INC. ARYLAND 21224	
	Pnysician		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition	plie that caused the deat one cause on each line.	n. Do not ente	er the mode of dyin	g, such as card	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
,09/	Medical  Examiner  Asician and  Be burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	2000						
O. Box 687	ath certifica ittending ph or use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregns 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown		ate of delivery Ionth Day Year				
rds, P	quires that the de n signed by the a uld be detached f	þ	Part II. Other significant conditions	contributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.		obacco use cor Yes 2. No	pkribute to the cause of death?
al Record	i: The law requir icate has been si r, page 2 should I	Completed						24a. Was autor perio 1 Pes	an 24b. osy rmed? 2 \( \text{No} \)	Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
of Vital	ding Physicien: The I h. After this certificate ha funeral director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No		ER/Outpatien		er: 4 Nursing	Home 5 Resid		her (Specify)
Division of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	e 28e. Place of Injury - At h	28b. Time of Injury		vat k? Yes 2 □ No	28d. Describe I	Street and Num	nred  nber or Rural Route Number,
á	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		4   Homicide	building, etc. (Specif		a occurred at the tin	me date and pla	City or Tou		nanner as stated
	To the Hospitel within 24 hours To the Funeral completely filled	Medical	(Check only 2 ☐ Medicel Execute)  29b. Signature and title of certifier	miner: On the basis of examina and manner stated.	tion and/or inv	vestigation, in my o	pinion, death oc	curred at the time.	date and place	ed (Month, Day, Year)
)	5 <u>8 5 8</u>	_	Mulle 1	allouton &	20	0	333/	6	230. Date sign	4-25-2005
	4		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type,	Print)	ewc	incle is	Scalt	4-25-2005
. #	St Regist		31. Date filed (Month, Day, Year) APR 2 9	James and State of St	tyro Ago	ale				

			For State Ragistrar	State of Ma	ryland / Depa	artment of H			giene 2	05	14611
	Dhusisi		Decedent's Name (First, Middle, Last)			·		2. Date of Dea Month		Year	3. Time of Death
	Physicia /Medic	al	William George Po		I				23 <sup>Day</sup> 2005		1724P. M
	Examin	er	4a. Facility Name (If not institution, give st 10011 Edward Ave.	reet and number)		4b. City, Town, or Bethesda	Location of Death	1	4c. County		
	Funeval		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h		lace (State or Foreign
	Funeral Director			M 2□F 7:	2 Yrs.	Months Days	Hours Min.	(Month, Day April 13			ington,D.C.
	D .		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	antion					0d. Inside City Limits
	shoved at	5	Maryland Montgomer	v	Bethe					, "	1 ☐ Yes 2X No
	the N 28a-1	Director	10e. Street and Number	<i>J</i>	500110	10f. Zip Code			10g. Citizen of W	/hat Coun	itry?
	3a or		10011 Edward Avenu	ıe		20814			United	Sta	tes
	death	Funeral	11. Marital Status	2. Was Decedent E Armed Forces?	ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span Mexican Puert	pecify Yes or No-			an Indian,
98	or Ita	y Fu	1 Never Married 2 Married	1 XYes 2 □ N If Yes, Give Year or Dates:C	Korean.	1 ☐ Yes 2X No	Specify:	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specify	TT	hite
Ö	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show Jicel Examinet must be notified at	ed by	3X Widowed 4 ☐ Divorced  15. Decedent's Education		1	dent's Usual Occup	ation		16b. Kind of Bu		duetne.
15	in 72 n "na	Completed	(Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired	during most of wor	king	Electr		lustry
212	d with giene ar tha	mo;	Elementary/Secondary (0-12)	College (1-4or 5-	Electi	ical Eng	ineer		Compar	y	
b	al Hy d otha	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nan			9)	
<u>\</u>	Men Men Marka Marka Marka	은	William George H					mine Go		O	0.44
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. I Health and Mental Hyglene them 27 is marked other than "natural" or I tams 23a or 28a-1 show other traumatic event, I'm McJical Examiner must be notified at		19a. Informant's Name/Relationship (Typ Deborah Gladstein/I	-		ng Address (Street) Mainsail					0879
	Heal Heal tam 2	1	20a. Method of Disposition	dagneer	20b. Place of Dispo	osition (Name of	T =	Pata 29,	20c. Location -		
OE .	Pages 1 and ment of Healt ant: If Itam 2 lury or other		1  Burial 2  Cremation 3  Re '4  Donation 5  Other (Specify)	moval from State	Cheltenham Ceme	Veteran's Lery			heltenh	am, N	Maryland
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Upenser	/	W01170	2. Name and Address Robert A. P 800 W. Mont	ss of Facility umphrey Fur	neral Home	e, Rockvil	le, I	nc.
	*		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused	the death. Do not en					Lylenk	Approximate Interval Between
	Physician		Immediate Cause (Final		ISLUE ATMER	osci strani	cton n.An	MAR	OLSETHE	- 11	Onset and Death
	/Medical Examiner		resulting in death)		a consequence of):		La real a fait				
	LXaniniei	_	Sequentially list conditions, b.		a consequence of):						
$\overline{}$	nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D00 to (01 23 t	a consequence or).						
ر ر	be executed sician and burial-transit	Examine	that initiated events c. resulting in death) Last	Due to (or as a	a consequence of):						
8760,	The law requires that the death certificate be executed as been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcal	d.								
9	ing pt e as tl	Med	IF FEMALE:								
Вох	death certifica attending phase as the	lan/	23b. Was decedent pregnant in the past 12 months?	Ic. If yes, outcome	2 Fetal death 3	Ectopic pregnancy	,		23d. Dat Mor	e of delive nth	Day Year
o.	that the de ed by the a detached	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time or death 5 t	Other (specify) _					
S, P	s that ned by deta	by Ph	Part II. Other significant conditions conf	tributing to death bu	ut not resulting in the u	underlying cause giv	en in Part I.	23e. Did to	obacco use contr	ibute to th	ne cause of death?
rds	quires en sign	ed b						101	∕es 2 🗆 No	3 🗌 Prob	ably 4 Munknown
Record	law requas been 2 should	Completed						24a. Was	an 24b. V	Vere auto	psy findings available impletion of cause of
<u>~</u>		Con						perfo	rmed?	eath?	2□ No
Vital	Physician: The this certificate rat director, pages	Be	25. Was case referred to medical examiner?	ospital:		Oth	000	ith (Check only o			D1 Q
of	Phys this at di	. To	1 X Yes 2 No '" 27. Manner of Death	1 Inpatie			4 🗆 Nulsing II	ome 5 Resid	dence 6x10the		(scene)
	ding Ih. Th. After funer	tion	1 🖾 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	Wor	k? Yes 2 □ No		,.,,		
Division	i or Attendii after death. Diractor: A	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, farm, st	reet, factory, office		28f. Location (S City or Tox	Street and Numb	er or Rura	I Route Number,
Ö	tai or Ati rs after d al Diract ed in by	Cert	4 Dilamoido	ballaling, etc	. (Opacity)			, ony or rov			
	To the Hospital or Attending within 24 hours after death.  To the Funaral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Phys 2 ▼ Medical Examin	ician: To the best of ar: On the basis of and manner sta	of my knowledge, dea examination and/or inted.	th occurred at the tir nvestigation, in my o	me, date and place prinion, death occu	, and due to the trred at the time,	cause(s) and ma date and place, a	nner as st and due to	ated. the cause(s)
	To the within To the comp	Ĕ	29b. Signature and title of certifier			29c. Licens			29d. Date signed April 24	(Month,	Day, Year)
•	V		> unatz			OCM	E		F	,	
	301,		30. Name and address of person who con		eath (Item 23a) (Type	. Print) 111	Penn Str	eet Ba	ltimore.	Mar	yland 21201
	" St	ate	ANA RUG(O	32 Registra	ar's Signature						
	Regist		APR 2 9 20	105 Bun	w # A	berte					

JET 05**-**028**7**9 Daniel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

LCI	. J. Pi	500	1 - For Unpend It	em 23a&27	per me G	843 Ce	artment -5-05 rtificate	of Health tas of Deati	and Me h	ental Hy	giene Rag. No.	005	The same of	612
	Physic	ian	1. Decedent's Name (First, Midd							2. Date of De		Year	3. Time o	
	/Medi		Daniel Joseph							April		2005°	3:10	Рм
7	Examir	ner	4a. Facility Name (If not institution 1109 Agnew Dr	n, give street and nu	mber)		Rocky	own, or Location	n of Death			ounty of Deat tgomer		
	Funeral	_	5. Social Security Number	6. Sex 1₺ M 2□ F	7. Age (In yrs. la:	st birthday)	If Under 1	Year If Unde	er 24 Hrs.	8. Date of Bi		9. Birt	hplace (State	or Foreign
-	Director		215-50-3946	1Å M 2□ F	50	Yrs.	Months	Days Hours	Min.	8. Date of Bi (Month, Di Nov. 2	1954		untry) aryland	
)	and w		Usual Residence of Decedent  10a. State 10b. Count	/	10c. City.	Town or Lo	cation			_			10d. Inside C	City Limits
	Manyli f sho	ō	Maryland Montg	omery		kvill								2 No
	r 28e	rec	10e. Street and Number	, omer y	Roci	KVIII	10f. Zip C	ode			10g. Citize	n of What Co	untry?	
	th with	a D	1109 Agnew Dr	ive			20	851			Unite	d Stat	es	
	parmit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event. I've M. cifcal Examiter rust be instilled at ance.	Funeral Director	11. Marital Status	Armed Fo		. 13.	Was Decede f Yes, specif	nt of Hispanic C y Cuban, Mexic	origin? (Spec an, Puerto R	city Yes or No lican, etc.)		Race - Ame Black, White	rican Indian,	
21215-0036	urs aft al', or	by F	1 📉 Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes Gi	ve		1 □ Yes 2]	No Specif	y:		S	pecify:	White	
5-0	72 ho	Completed by	15. Decede	nt's Education est grade completed)		16a. Dece	ient's Usual	Occupation	ast of working	a	16b. Kind	of Business/	Industry	
2	vithin ne. <b>hen "</b>	m pt	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.		done during mo retired)		3				
	Hygie thert int, th		12 17. Father's Name (First, Middle	Last)			Carpe		her's Name	(First, Middle		pentry		
aŭ	d ba f	o Be	Thomas E. Pi							Murra		inane)		
Maryland	shoul nd M	2	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	g Address (	Street and Num				own, State, 2	tip Code)	
	alth a		Thomas Pistole	, Jr./Brot	her			Drive,					0851	
Baltimore,	of He of He fitem		20a, Method of Disposition 1 X Burial 2 ☐ Cremation	3 Demoval from		ce of Dispo	sition (Name	of	May 1	ite		tion - City or	Town, State	
Ĕ	Pag ment ent: I ury o		`4 □Donation 5 □ Other (		Park	Lawn M	emorial	Park	2005	,	Rockv	ille,	Maryla	nd
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j.	/Medical Examiner		lossing in douting	Due to	(or as a conseque	ence of):								
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	ocutad nd transit	Examin	Cause (Disease or injury that initiated events	C										
8760,	icate be executad physician and s the burial-transit	al Ex	resulting in death) Last	Due to	(or as a conseque	ence of):								
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P.O. Box (	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live t	tcome of pregnanc pirth 2 ☐ Fetal d nant at time of dea own	eath 3	Ectopic preg Other (spec				230	d. Date of deli Month	,	Year
	es that gned b	by Pi	Part II. Other significant conditi	ons contributing to d	eath but not result	ing in the u	nderlying cau	se given in Part	H.	23e. Did t	obacco use	contribute to	the cause of	
ord	w requir been si should	ted								1 🗆 '	Yes 2 1	No 3 ☐ Pro	bably 4 🎾	Unknown
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Vita	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 X Yes 2 □ No	Hospital:	Inpatient 2 E	P/Outpatien	2004			Check only o		1011 /0		
o	문 는 FE	n; To	27. Manner of Death	28a. Date		8b. Time of		Injury at Work?		d. Describe			ify)Scene	7
0	Attending F r daath. sctor: After by the funer	atio	E	igation	in, Day rear)	Injury	М	1 Yes 2	No					
Division	or Atter	Certification:	3 Suicide 6 Could 4 Homicide deterr	nined 286. Place	of Injury - At hom ng, etc. (Specify)	ιθ, farm, str	eet, factory,	office	28	f. Location (: City or Tox	Street and N vn, State)	lumber or Ru	rai Route Num	iber,
	To the Hospitel or Attenc within 24 hours after daath To the Funerel Director: completely filled in by the	Medical Ce	(Check only 2. Medical one)		best of my knowle asis of examinationer stated.	edge, death n and/or inv	restigation, ir	my opinion, de	eath occurred	at the time,	date and pla	ace, and due	to the cause(s	5)
	To To Con	2	29b. Signature and title of certific	i n.D			29c. l	icense number				igned (Month		
Λ	okurg		20 Nome said addition		o of death //	12a) (T:	Deien)	OCME		I A	April	26 200	)5	
P	U -			I, mid				Penn St	treet	Balti	more,	Mary1	and 21:	201
	Sta Registi		31. Date filed (Month, Day, Year	<i>A</i> .	legistrar's Signatur	re Lea	S.							
	negisti	rai	APR 2 9	CUBY	ALL COM	D. Carrie								

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health an		-	•	
		•	1- State Registrar Certificate of Death	na went	ai nygiei. Reg. f	2000	11.010
			Decedent's Name (First, Middle, Last)		ate of Death		3. Time of Death
	Physicia /Medic		DAXIAH GENEA RIVERS	1 20	Nonth E	year Year	-08:21AM
- *	Examin		4a. Eacility Name (If not institution, give street and number) 4b. City. Town, or Location of D	Death		c. County of Deat	
			The Jehns Hopkins Hospital Balfiner	e Co	Ly	NA	
	Funeral		5. Social Security Number 6. Sex 7. Age (In √s. last birthday) H Under 1 Year If Under 24 Months Days Hours Yrs.	Min. 8. Da	ate of Birth North, Day, Yea 22. 2	9. Birt 005	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent		V. 77. 7	.003	1110
vlan	how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Ma Ma	88-f.s	ecto	MD BAKTIMORE WINDSOR MILL				1 ☐ Yes 2 No
with	e or 2 lbe n	Funeral Director	10e. Street and Number 1729 WINDING BROOK WAY 21244		10g. 0	Citizen of What Co USA	untry?
death	ns 23	era	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	in? (Specify Y	res or No-	14. Race - Ame	
<b>6</b>	or Iter	Fur	Armed Forces? If Yes, specify Cuban, Mexican, F  1 □NNever Married 2 □ Married I □ Yes 2 12 No Specify:	Puerto Rican	i, etc.)	Black, White	
003	Len.	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:				ACK
15-(15-15-15-15-15-15-15-15-15-15-15-15-15-1	"nett	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired)	of working	16b.	Kind of Business/	Industry
12 With	then then	omp	Elementary/Secondary (0-12)  N A  N A  N A			NA	
Maryland 21215-0036 d2 should be filed within 72 hours after death with the Maryland	othe vent.	BeC	17. Father's Name (First, Middle, Last)  18. Mother's		t, Middle, Maid	en Sumame)	
ylar	Menta arked atic e	To E	DELPHONSO RIVERS SHERA		SNEAD		
Aar 2 sho	and Is n		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of Name (Name				
O, 1	Health tem 27 other tr		SHERAUN SNEAD - RIVERS 1729 WINDING BRC  20a. Method of Disposition 20b. Place of Disposition (Name of	Date Date		Location - City or	MILL, MD
Mor	t: If It		1 95 Rurial 2 Cromation 3 Permoval from State   cemetery, crematory or other place)	1.29·a		TO. MO	
Baltimore,	Department of importent: If Its any injury or or once.			-			
Ö	limpo any once		22. Name and Address of Facility VAUGHU C. GREENI DIST BHULL NHILL	PIKE 1	BAUD. 1	10 21229	
	28.4		23a. Part1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart ure. List only one cause on each line.			A.T.	Approximate Interval Between
4	hysician		Immediate Cause (Final disease or condition				Onset and Death  / hour
	/Medical xaminer		Due to (or as a consequence of):				
		-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
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760,	an an		resulting in death) Last  Due to (or as a consequence of):				
		lical	d				
Box 68	ding p	by Physiclan/Med	IF FEMALE: 23c. If yes, outcome of pregnancy				
Box	atten for us	clan	in the past 12 mgmths?  1 Live birth 2 Fetal death 3 Ectopic pregnancy			23d. Date of deli Month	very Day Year
O E	y the ached	nysi	1 Yes 2 Sto 9 Unknown 9 Unknown				
Records, P.O	signed by the atte	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	2		-	the cause of death?
ord:	been sig				1 🗌 Yes	2.500 3 Pr	obably 4 Unknown
Records,	has be	Completed		2	4a. Was an autopsy	prior to d	topsy findings available completion of cause of
				1	performed?	death? lo 1 ☐ Yes	2 No
of Vital	certificate rector, pag	Be	examiner? / Hospital: /	of Death (Che		. To:: .:	
of a	두명	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		Describe how in	6 ☐Other (Spec	ory)
Vision	ath. r: Afte	atio	1 Maturat 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 □ No	0			
Division I or Attending	recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Lo	ocation (Street lity or Town, Sta	and Number or Ru ite)	ral Route Number,
الم	urs afi orel Di						
HOS	within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and process of examination and/or investigation, in my opinion, death and manner stated.	place, and di occurred at l	ue to the cause the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
o the	within Fo the	₩ M	29b. Signature and title of certifier 29c. License number		29d. C	ate signed (Month	n, Day, Year)
) [	,		▶ Janus Sulled, MB		AK	ul 22,20	05
1	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
V			Janine Bullard, MD 600 N. Wolfe Street; Baltimore, MD  31. Date filed (Month, Day, Year)  32. Registrar's Signature  APR 2 9 2005	21287			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 2: 50 P M Kenneth Jerome Ross 04 2005 22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore City Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 №M 2 🗆 F Months Hours Min. 55 Yrs. **Director** 213-60-0444 01/11/1950 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or Items 23a or 28a-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-1 show the Medical Examinar must be rollified at 1 ☐ Yes 2 ₩No MD Baltimore Baltimore Direct 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 6318 Sherwood Road, 1st Floor 21239 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married O. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: If Yes, Give Year or Dates: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Horticulture Elementary/Secondary (0-12) College (1-4or 5+) Landscaper 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Kulis Edward Ross Bertha ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Beeman-Young/Fiancee 6318 Sherwood Road, 1st Floor Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Apr 28 ō permit. Page Department Important: If Beltsville, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | Inc. 2005 injury 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives any in MOORSC 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** EPSIS disease or condition resulting in death) weiks /Medical Due to (or as a consequence of): **Examiner** CIRRIIDSIS) ALCOHOLIC FAILURE LIVER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant I ive hirth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 √Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate has 2 No 1 ☐ Yes To the Hospital or Attanding Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours after To the Funeral Dirac McCertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2438946 - E13 04-22-05 M.O 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SKMY , BALTIMOKE SHAHZAD UNI VERSITY 21218 A. USMANOI 201 EAST MD 31. Date filed (Month, Day, Year) 32. Regisar's Signature

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Registrar

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iner		a. Facility Name (If not institution, give North Arec	vel Hosp-tal		4b. City, Town, C	Burni		Anne	y of Death	
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20	11	Isual Residence of Decedent  Oa. State 10b. County  aryland Anne An		Town or Lo						10d. Inside City Limi
Direct	10	0e. Street and Number  402 Rugby Aven		TUTING	10f. Zip Code	225		10g. Citizen of U.S		
by Funeral Directo	1	Marital Status     Never Married 2  Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1959—1			,	Specify Yes or No- to Rican, etc.)	14. Rad Bla		
Completed b		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E  (Specify only highest grave)			lent's Usual Occup kind of work done OO NOT use retire	oation during most of wo	orking	16b. Kind of B		
		Elementary/Şecondary (0-12) 12th  7. Father's Name (First, Middle, Last	College (1-4or 5+)	Serv	ice Tech	•	me (First, Middle,	Sears		ebuch
To Be		Harry 9a. Informant's Name/Relationship (	George Resuta	19h Mailic	an Address (Street	Mar	y Pretko			n Code)
		Edith Resuta / v	wife	402 R	ugby Ave		altimore Date	, Maryl	and 2	1225
	21	0a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special	Removal from State cem	etery, cren	sition ( <i>Name of</i> natory or other pla 11 Cemete	ery 4/30	0/2005		ore,	Maryland
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cai	r.	ial initiated events	c.	y seath 3	Ectopic pregnancy Other (specify)	y		1	ate of delive	ery Day Year
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 10/a Dhannor April 27 2005 13:38 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner AUGSBURG LUTHERN HOME BALTIMORE If Under 24 Hrs. BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 200KF Yrs. 81 Director NOV. 16 1923 PENNSLYVANIA 172-20-8477 Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mantal Hygiene.
ant: if Item 27 is marked other than "naturel; or items 23s or 28s-f show ury or other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 X Yes 2 No Directo MARYLAND N/ABALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3408 GRANTLEY ROAD 21215 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Merried 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 🗓 No Specify: ģ Specify: 3 X Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) CHILD CARE 12th grade SHELTER MANAGER 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Be MOLLIE MOORE GEORGE SLOAN 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janette S. Cambell/Daughter 3408 Grantley Rd., Baltimore, Maryland 21215 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Department of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) ARBUTUS MEMORIAL PARK 05-02-05 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNEFAL HOME F.A. 1206 W NORTH AVENUE Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examine Jar Elinson sician and burial-transit Hospital or Attending Physician: The law requiras that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or as a consequence of): Box 68760. attending physician for use as the burie Physician/Medical Due to (or as e consequence of): resulting in death) Last signed by the at d be detached for of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? i certificate has t 1 Yes 27 No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2€ No this ours after death.

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Z3, Z001 VOOA 30. Name and address of person with completed cause of deeth (Item 23e) (Type, Print) 13 Many Jef 25 Cibell Krustevstown 31. Dete filed (Month, Dey, Yeer) 32. Registrar's Signature State Registrar

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			For State Registrar		State of	Marylar			nt of H te of L		and M	lental Hy	giene	201		1	617
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	Physici /Medic		Clara	M	ae	St	reet					Month April	Day 23		Year 0.5	8:4	3 P <sup>M</sup>
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Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		21. Signature of Funeral Serv	ce Licens	000	d0 (	) ()   2	2. Name a D 1	ind Addres 211in 57 N	s of Facilit ger F	uner	al Home Woodst	e took	W.	cain	ia	
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	V		30. Name and address of pers	on who co	empleted cause	of death (Iter	п 23a) (Туре,	Print)			-						
	- V		CHANDRA SAJJ	A M.D	. P.O	.BOX64	O HOI	LYWO	OD, ME	. 206	536						
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/Medic Examin		4a. Facility Name (If not institution, give	re street and number)	4b. City, Town, or Location of Death	111	4c. County of Death
		Sinai Hospita		Baltimore		
Funeral Director		242-44-8546	Sex 7. Age (In yrs. last birthday)  √X  Yrs. 7.3  Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye)	9. Birthplace (State or Foreig Country) NC
ryland thow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limit
the Ma	recto	MD NA  10e. Street and Number	Baltimo	re 10f. Zip Code	10g.	Y Yes 2 N Citizen of What Country?
3a o	0	3703 Seven Mi	le Lane	21215		U.S.A.
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evantment rust be redilized at	by Funeral Director	11. Marital Status 1 Never Married 2 Married	1XX es 2 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
2 should be filed within 72 hours a and Mental Hygiene. Is marked other than "natural", o aumatic event, the Neulical Evan	ed by	3 Widowed 4 ☐ Divorced  15. Decedent's E	If Yes, Give Year or Dates:	1 ☐ Yes 2 █ No Specify:	168	Specify: Black  D. Kind of Business/Industry
thin 72 e. an "ne Nedik	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) (Give life.	dent's Usual Occupation a kind of work done during most of wor DO NOT use retired)	king	,
led wit ygiene ygiene yer tha		12th grade	na Cr	ane Operator	- /First Mindello Mari	Beth Steel
d be fi ental H ced ott	o Be	17. Father's Name (First, Middle, Last			ne (First, Middle, Mai ell Spene	,
shoul and Me s mark umati	To	John Henry Smit 19a. Informant's Name/Relationship		ing Address (Street and Number or Ru		
and 2 saith a n 27 ls		Lydell Craig		Kelway Road,		
Pages 1 nent of He ant: If iten ary or oth		20a. Method of Disposition  1538urial 2 □ Cremation 3 □  14 □ Donation 5 □ Other (Speci	☐ Removal from State 20b. Place of Dispression Commetery, cre	matory or other place)		c. Location - City or Town, State
# E E E		<ul> <li>4 Donation 5 Dother (Special Signature of Funeral Service Lipe</li> </ul>		n Forest Vet 5	/6/05	wings Mills, Md
Depariment of the parameter of the param		Y Sula 1	1// / M	2. Name and Address of Facility arch F/H West 300 Wabash Ave	, Baltim	ore, Md 21215
		Part1. E / er the disease, or conshock, in heart failure. List only immediate Cause (Final	rplications that caused the death. Do not en	ter the mode of dying, such as cardiac	or respiratory arrest,	
Physician /Medical		disease or condition resulting in death)	a. Atheros clerotic Co	rdiovascular di.	sease	years
Examiner		Sequentially list conditions,	b. Hypertension			Yeurs
cuted nd ransit	Examiner	if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. D'ab			years
eath certificate be executed attending physician and for use as the burial-transit	cai Ex	resulting in death) Last	Due to (or as a consequence of):	a		years
ntificating physes as the	Medi	IF FEMALE:	11-1102	Y		
the death ce / the attend ched for use	by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year
icien: The law requires that the death certificate has been signed by the atterector, page 2 should be detached for	d by Pt	Part II. Other significant conditions	contributing to death but not resulting in the u	underlying cause given in Part I.		co use contribute to the cause of death?  2 □ No 3 □ Probably 4 ☑ Unknow
law req as beer 2 shou	ojete				24a. Was an	24b. Were autopsy findings availab
: The la cate has	Completed				autopsy performed 1 1 Yes 2	
Physicien: this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:	Othor	th (Check only one)	
Phys this ral di	1: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury 28b. Time of	of 28c. Injury at	ome 5 Hesidenc	e 6 Other (Specify) injury occurred
2 € ⊆	cation	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	20	Work? 1 ☐ Yes 2 ☐ No	206 Lanatina (Street	at and Number or Rural Route Number.
rs after o	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, ractory, office	City or Town, S	
To the Hospital or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medicai	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of my knowledge, dea miner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	V O	29c. License number	I .	Date signed (Month, Day, Year)
, XI		muden L D L  30. Name and address of person who	o completed cause of death (Item 23a) (Type	D50500	I A	DRIL 26, 2005 WORE MARYLAND 2122
671		FREDERICK B.	KOTLER 10 NORTH	6	BALTI	HOME MARYLAND 2120
St. Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	location		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 Year April 22, **Physician** 6:00 A. M Makeka Knight Slay /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Howard 7460 Terry Street Ft. Meade | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 27, 1974 9. Birthplace (State or Foreign Country) ALADAMA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 WF 30 419-06-3189 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itams 23a or 28a-f show the Medical Examinational be notified at 1 Yes 2 No MD Howard Ft. Meade Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20755 7460 Terry Street USA Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Director 12 Cosmetics 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, size. 17. Father's Name (First, Middle, Last) Lorretta D. Knight Victor Freeman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lorenzo Slay / Husband 7460 Terry Street, Ft. Meade, Maryland 20755 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat'l Cem. 5/10/2005 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fleck Funeral Home, Inc. 21. Signature of Funeral Service Licensee 7601 Sandy Spring Road, Laurex, Marykand 20107 Approximate Interval Between Onset and Death 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat, failure. List only one cause on each line. Immediale Carde (Final **Physician** BREAST CANCER METASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) hed t 1 ☐ Yes 2 ☐ No 9 Unknown signed by th 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 12 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA : After this funeral o 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 🗌 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number umpriller no Di6619 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SQUARE DR. BALTIMORE 6.41 CNERGARA - SOARES MD. 21236 9940 FRANKUN 31. Date filed (Month, Pay Year) APR 2 9 2005 32. Figistrar's Signature State Registrar

			For State		State of Ma	-	epartment of F Certificate of		-	9000	14620
			Registrar  1. Decedent's Name	e (First, Middle, Las	t)		oramouto or	Douth	2. Date of Dea		3. Time of Death
	Physicia	_	Lillian D	Dale Snvd	er				Month April	27, 2005	4:00 AM M
	/Medic Examin				street and number)		4b. City, Town, o	r Location of Death		4c. County of De	eath
			Gilchrist	t Center	for Hospi			Towson		Baltimor	ce
	Funeral		5. Social Security No	1	9x 7. Ag □M 2 <b>52</b> .F	e (In yrs. last birth	Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	lirthplace (State or Foreign Country)
	Director		219-38-48	394		63 Y	s.		07/25/	1941 MD	
	and and	ŀ	Usual Residence of 10a. State	10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Mary 1 sh	ţō	MD	Baltimo	re	Lutherv	ille Timon	ium			1 ☐ Yes 2 🕱 No
	1 the	rec	10e. Street and Nun			1	10f. Zip Code			10g. Citizen of What	Country?
	h with	a D	103 Trega	arene Roa	đ		21093			United St	ates
	ems arms	Funeral Director	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of H If Yes, specify Cub.	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14. Race - Ar Black, W	nerican Indian, hite, etc.
36	or It	y Fu	_	ed 2 Married	1 ∐ Yes 2 🗖 If Yes. Give	No	1 ☐ Yes 2 ☑ No	Specify:	,	Specify: Wh	
5-0036	72 hours after death with the Maryland naturel; or items 23s or 28e-f show Isal Examinat must be notified at	ed by	3 Widowed	/-	Year or Dates:	162 [	ecedent's Usual Occup	nation		16b. Kind of Busines	
15	n 72	Completed		15. Decedent's Ed	de completed)		Give kind of work done ife. DO NOT use retire	during most of work	king	Health Ca	
2121	within iene.	omp	Elementary/Secon	ndary (0-12)	College (1-4or : 2		ical Coord	inator			
p	filed Hyg other	Be C	17. Father's Name (	(First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	
<u>lar</u>	All be All be All be All be riked tic ex	To B	Emil Leo	nard John	son			Jesse Li	llian Re	ynolds	
Maryland	12 should be filed within 'h and Mental Hygiene. 7 Is marked other than "i raumatic event, tre Med	1 30		ame/Relationship (7			Mailing Address (Street				
Σ,	and and and and and and and and and and			yder Johns	on		Internatio				
ore	ges 1 t of H if Item or oth		20a. Method of Disp 1 Burial 2		Removal from State		isposition (Name of crematory or other pla	1	Apr 28	20c. Location - City	
Ë	tment tent:		` 4 □ Donation	5 Other (Specify	1)	Chesap	eake Cremat		2005	Beltsville	, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Department of Health and Mantal Hygiene. Department: If Item 27 Is marked other than "naturel", or Items 23a or 28e-1 show eny injury or other traumatic event, 11e Marylad Examinar must be notified at once.		21. Signature of Fu	ineral Service Licen	W.	ss of Facility and Funera Pastures		natives Baltimore,	Maryland		
			23a. Part 1. Enter the	he disease, or comp	plications that cause one cause on each li	the death. Do no	t enter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
	Physician	l u	Immediate Cause ( disease or conditio	(Final	. m		atic (un				Onset and Death
	/Medical		resulting in death)		Due to (or as	a consequence of	):	)			
В	Examiner	_	Sequentially list co	nditions,	b						
	ed isit	line	Sequentially list confirmed in the confirmed confirmed confirmed confirmed confirmed confirmed confirmed confirmed confirmed confirmed confirmed confirmed confirmed confirmed confirmed confirmed confirmed confirmed conf	nmediate arrying injury	Due to (or as	a consequence of	):				
B	icate be executed physician and s the burial-transii	Examiner	that initiated events resulting in death) I	5	c Due to (or as	a consequence of	):				
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89	ificate g phy as the	edicai									
Box	The taw requires that the death certificate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was deceden		23c. If yes, outcome	of pregnancy 2 Petal death	3 □Ectopic pregnanc	v		23d. Date of	
	ne deat the attr hed for	sicia	in the past 12	X No	4☐Pregnant a		5 Other (specify)			Month	Day Year
P.0	that the de ed by the detached	Phys	9 Unknowh					- 1. B. al	OZo Did t	abassa usa santsibuts	to the equal of death?
	res tha igned be def	by	Part II. Other signif	ricant conditions c	ontributing to death t	ut not resulting in	he underlying cause gi	/en in Paπ I.			to the cause of death?  Probably 4  Unknown
orc	w require been si	eted									
3ec	e taw has b	Completed							24a. Was autor perfo	psy prior to prior to prior to prior to prior to prior to	autopsy findings available o completion of cause of ?
alF			05.14						1 ☐ Yes	2 No 1 Y	es 2 No
of Vital Records,	ysicien: is certific director,	) Be	25. Was case refer examiner?		Hospital:	ent 2 ER/Out	atient 3 DOA Ott	26. Place of Dea	ome 5 Resi		nonital (I as airs.
of	Phys er this eral di	n: To	27. Manner of Deat		28a. Date of Inju		ne of 28c. Inju	ry at		how injury occurred	DECITY) UT OSPICE
ion	nding f ath. r: After e funer	atio	1 Natural 2 Accident	5 Pending investigation		ly rear) In	ury Wo	Yes 2 □No			
Division	Il or Attendil after death. I Director: A d in by the fu	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Place of in	jury - At home, fari tc. (Specify)	n, street, factory, office		28f. Location (: City or Tox	Street and Number or wn, State)	Rural Route Number,
Ö	tal or rs afte el Dir ed in	Cer			Dallowig, o						
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only		niner: On the basis of	f examination and	death occurred at the ti or investigation, in my	pinion, death occur	rred at the time.	date and place, and o	lue to the cause(s)
	To the h within 24 To the F complete	Medi	one) 29b. Signature and		and manner st	ated.	29c Licens	se number		29d. Date signed (Mo	onth, Day, Year)
	To To		250. Signature and	1 N V	11-0	220	020	100		April 2	7. 200.5
	2		70 Name and 1	MAN	completed cause	Teath (Item 23a) (	ivne Print)	~~~ <u>~</u>		Price	1-0
	10		W. A. K	ley 6	GBMC	6701 N	29c. Licens 025  ype, Print) Charles S	t. Balt	o. md	2/20%	
	Sta		31. Date filed (Mon		32. Regist	s Signature	1. 1. s.				
	Regist	ar		APR	2 9 2005	Stolen A	" Gosse	S			

expired 4-25-05 e4:00 Am

Lillian Soyder

1			1- For Unpend Item 23a&27 per me G843 5- Registrar Certification	ment of Health and Me 15 tas ficate of Death	ntal Hygier	ne No2005	14621
	Physici	an	1. Decedent's Name (First, Middle, Last)		. Date of Death APRIL 26 <sup>D</sup>	Day OOO Hear	3. Time of Death
	/Medic		Corey C.	biieppard	APRIL 26	, 2005 ear	4:06 P M
	Examin	er	SINAI HOSPITAL	BALTIMORE CITY		4c. County of Death	
35.21	Funeral Director		219-13-4139 XXM 2 F 18 Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Yea)	ar) Cour	place (State or Foreign htry) MD
4 /	and and		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Loca	tion		1	0d. Inside City Limits
	Maryl	ō	MD NA Dalhiman	_			1 XYes 2 □ No
	28a	rec	MD NA Baltimor  10e. Street and Number	10f. Zip Code	10g. (	l Citizen of What Cour	ntry?
	death with the Maryland ms 23a or 28a-f show	Funeral Director	3906 West Rogers Ave	21215		U.S.A.	
	deat	ner		s Decedent of Hispanic Origin? (Species, specify Cuban, Mexican, Puerto Ri	fy Yes or No-	14. Race - Americ Black, White,	
920	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If itam 27 is marked other then "natural", or Itams 23a or 28a-f show or other traumetic event, Its Modical Exami	by	XXNever Married 2 ☐ Married 1 ☐ Yes 2 🕅 No	Yes ZXI No Specify:	Jan, 616.7		ack
5	72 ho	eted	15. Decedent's Education 16a. Deceder (Specify only highest grade completed) (Give kir.	it's Usual Occupation	16b.	Kind of Business/Ind	dustry
Maryland 21215-0036	d within jiene. r then	Completed	Elementary/Secondary (0-12)   College (1-40r 5+)	d of work done during most of working NOT use retired) ter Attendent		AMC	
þ	e fileo al Hyg otha vant,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (I	First, Middle, Maid	en Sumame)	
<u>/lar</u>	ould b Menta arkad	To	Cornelius Sheppard	Renee So	cott		
lar	2 sho	1.70		Address (Street and Number or Rural I	Route Number, City	or Town, State, Zip	Code)
	l and tealth im 27 thar to		Renee Scott -Mother 3906  20a. Method of Disposition 20b. Place of Dispositi	West Rogers Ave		imore, M Location - City or To	
وّ	if its		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	fory or other place)			
altimore,	iit. Partmer artmer ortant injury			orial Park 5/2, lame and Address of Facility	705 Rar	ndallsto	wn, Md
Ba	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or othar once.		Mar Mar	ch F/H West	) = 1 + d == = .	- M -	21215
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter	O Wabash Ave, I the mode of dying, such as cardiac or n		ce, Md	21215 Approximate
	Pnysician	, Z ni	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Pulmonary hemorrhage)	yo with wageulitia			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a.   Pulmonary nemorrna   Due to (or as a consequence of):	se with vascuittis			
	Examiner		Sequentially list conditions.				
	ad sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury				
	xecute and II-tran	Examiner	resulting in death) Last  C. Due to (or as a consequence of):	<del></del>			
8760,	cate be executed obysician and the burial-transit						
9	certificate iding phys	edic	0.				
Вох		In/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ec	etopic pregnancy		23d. Date of delive	ry
	that the death ed by the atter detached for u	Physician/Medical	1 Yes 2 No 4 Pregnant at time of death 5 0	ther (specify)		Month	Day Year
P.O.	that the de ed by the detached	Phy	9 Li Unknown	ah ian an	02a Did tahasas		a course of decays?
Division of Vital Records,	sign sign 1 be	by	Part II. Other significant conditions contributing to death but not resulting in the under	orrying cause given in Part I.	1 ☐ Yes	use contribute to th	ably 4 \(\begin{array}{c}\text{Unknown}\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
00	law asb 2st	Completed			24a. Was an autopsy	24b. Were autor	osy findings available inpletion of cause of
<u> </u>	sician: The lav certificate has rector, page 2	Con			performed? Yes 2□ N	death?	2□ No
/ita	Physician: this certific al director,	Be	25. Was case referred to medical examiner?  Hospital: ***.	26. Place of Death (0	Check only one)		
of	Physical direction	- T	1 M Inpatient 2 □ ER/Outpatient		5 Residence	6 ☐Other (Specify	")
on	ding f h. After funer	tion	1 X Natural 5 ☐ Pending (Month, Day Year) Injury	28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	2. Describe now in	dry occurred	
<u>.is</u>	Attan deat ctor: y the	fica	3 Suicide 6 Could not be			and Number or Rura	l Route Number,
Dİ	el or , after il Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, Sta	ite)	
	To tha Hospitel or Attanding Physician: The within 24 hours after death. To tha Funaral Director: After this certificate his completely filled in by the funeral director, page	edical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death or 2 Medical Examiner: On the basis of examination and/or invession and manner stated.	ccurred at the time, date and place, and tigation, in my opinion, death occurred	d due to the cause( at the time, date a	(s) and manner as stand due to	ated. the cause(s)
	o tha vithin o tha omple	Mec	29b. Signature and title of pertifier	29c. License number	29d. D	ate signed (Month, L	Day, Year)
	F S F Ö		I took with	OCME	APF	RIL 27, 20	005
_			30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	11 PENN STREET, B	ALTIMORE,	MARYLAND	, 21201
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 9 2005				-
	- negisti	ш	MINA J 2000   SERVER AND				

Bonnie Shifflett Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-02917 State of Manyland / Department of Health and Mental Hygiene 123a, 27, 28a-1 per me G843 5-9-05 tas

Registrate and item #20b PER FH C842 4995 (1934) Reg. No. RJ 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer Month **Physician** Bonnie Ann Shifflett April 2005 07:25 a. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3727 Eastern Avenue, Apt #2, Rear Baltimore
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 218-70-6239 1 ☐ M 2 🖫 F Director 48 7-26-56 MO Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show The Medicul Exact tract that be notified at MD Baltimore 1 Xes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3717 Eastern Avenue 21224 U.S.A 23a Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give — Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or Items within 72 hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify.White 1 ☐ Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) other than Elementary/Secondary (0-12) filed within 11th Barmaid Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ss 1 and 2 should be fi of Health and Mental F I Item 27 Is marked ot Harold Shifflett Elizabeth Epp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Wise 3227 Uniontown Way. Abington, MD 21009 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of F
Important: If Ite
any injury or ot Sacred Heart 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wesley Chavis, Jr. 2007 Eastern Avenue Baltimore, MD 21. Signature of Funeral Service 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each list Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Combined Alcohol and Drug(Fluoxetine and Quetiapine) Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury Dualto (or se a noneaquanea of) Examine signed by the attending physician and doe detached for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Records, P.O. ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been ; 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 \sum No 24a. Was an autopsy certificate has 1 Yes 2 🗆 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Describe how injury occurred Unik SCENC 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) Found: 6:45 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 X No investigation 4-27-05 2 Accident 6X Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found: Residence 28f. Location (Street and Number of Rural Route Number, City of Town, State B/2/ Eastern Ave., Apt.#2, Rear, Baltimore City, MD 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as death.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and litt 29c. License number **OCME** April 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAN 111 Penn Street Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 9 2005 Registrar

			For	State of Maryland	•			Mental Hyg	iene	
			1 - State Registrar		Cert	ificate of	Death		g. No. UU	14623
П	Physici	an	Decedent's Name (First, Middle, Last)	11 + 0				2. Date of Deat Month	Day Year	M
	/Medio		4a. Facility Name (If not institution, give s	Thomas James Sc treet and number)		4b. City, Town, o	r Location of Dea	April April	28, 2005 4c. County of De	1:50 A
	LAGIIII	ICI	8521 Meadow	lark Lane		•	Bethesda		Mon	tgomery
	Funeral		Social Security Number     6. Sex			If Under 1 Year Months Days	If Under 24 Hr Hours Mir	s. 8. Date of Birth	9. B	rthplace (State or Foreign country)
	Director		577-60-6533 Usual Residence of Decedent	90	Yrs.			January 1	4, 1915	Arizona
	yland yland		10a. State 10b. County	10c. City, 1	Town or Loc	ation			<del></del>	10d. Inside City Limits
	e Mar Sa-1 si	ctor	Maryland Montg	omery			Bethesda	l .		1 ☐ Yes 2X No
	with th	Director	10e. Street and Number			10f. Zip Code		10	ng. Citizen of What C	Country?
	ns 23	Funeral		wlark Lane 12. Was Decedent Ever in U.S.	13. W	as Decedent of H	20817	Specify Yes or No-	Unite	d States
9	after d or Iten	Fun	1 ☐ Never Married 2 🕅 Married	Armed Forces? 1 ☐ Yes 2 X No		Yes, specify Cubi □ Yes 2 <b>X</b> No		Specify Yes or No- rto Rican, etc.)	Black, Wh	
5-0036	filed within 72 hours after death with the Maryland Hygiene other than "natural", or Items 23a or 28a-f show out, the Madical Exact her must be maiffied at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			Specify:		Specify:	White
<u>1</u>	n 72 h "natu	Completed	15. Decedent's Educ (Specify only highest grade		16a. Decede (Give k. life. Di	int's Usual Occup ind of work done O NOT use retired	ation during most of w	orking	16b. Kind of Busines	s/industry
2121	d withing in the M	оше	Elementary/Secondary (0-12)	College (1-4or 5+) 4			Clerk		United St	ates Senate
밀	al Hyg	BeC	17. Father's Name (First, Middle, Last)					ame (First, Middle, M		
<u>yla</u>	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene Is marked other than "natural", or Items 23a or 28a-1 show aumatic event, the Medical Examiner must be notified at	To		d A. Scott					ne E. Roug	
Maryland	s 1 and 2 should if Health and Men item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Ty)						City or Town, State,	
<u>6</u>	Health Health tem 27 other tra		Mary K. Scott  20a. Method of Disposition	20b. Plac	e of Disposi	tion (Name of	1		sda, Mary 1 20c. Location - City o	
altimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 X Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	atory or other place		2. 2005 S	ilver Spri	ng, Maryland
ati	permit. Departmine importa any inju		21. Signature of Funeral Service License		22.	Name and Addre	ss of Facility Re	bert A. I	umphrev F	uneral Home/ onsin Avenue
<u> </u>	8919		Very )	yeart M00335	Be	thesda,	Marylano	1 20814-35	501	onsin Avende
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death. I e cause on each line.	Do not enter	the mode of dyir	ig, such as cardi	ac or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Lung Cance						2 Years
	Examiner			Due to (or as a consequer	ice ory.					
	<b>2</b> = = = = = = = = = = = = = = = = = = =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequer	nce of):					
	ecute and I-trans	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequen	oce of):					
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687	ifficate g physas the	Physician/Medical	0							
ŏ	leath certific attending pl	an/N	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de		ctopic pregnancy	,		23d. Date of de	,
O. B	ie dea the at hed fo	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of deat		Other (specify)			Month	Day Year
Δ.	The law requires that the de te has been signed by the a rage 2 should be detached f		Part II. Other significant conditions con	tributing to death but not resulting	ng in the und	lerlying cause giv	en in Part I.	23e. Did tob	acco use contribute t	to the cause of death?
rds,	quires n sign ald be	d by		Colon Cancer				1 🔀 Ye	s 2□No 3□P	robably 4 Unknown
Record	aw requ s been 2 shoul	Completed	Core	onary Artery Di	isease			24a. Was ar		utopsy findings available
ž		Som						autopsy perform		completion of cause of
Vita	sicien: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	ospital:	~	04		ath (Check only one		
	Phys this ral di	: To	1 ☐ Yes 2 X No  27. Manner of Death	1   Inpatient 2   ER	VOutpatient Bb. Time of	3□ DOA Oth 28c. Injur		Home 5 X Resider	nce 6 Other (Spe	ecify)
on	nding f ith. :: After e funer	ation	1 X Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No		,,	
Division of	I or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stree	et, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	tural Route Number,
	oital or A urs after rel Direc lled in by		14							
	Hospital 24 hours a Funerel I stely filled	edical	29a. Certifier  (Check only 2 Medical Examin one)	ician: To the best of my knowle er: On the basis of examination and manner stated.	edge, death on and/or inve	occurred at the tine stigation, in my o	ne, date and plac pinion, death occ	e, and due to the ca surred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Me	29b. Signature and title of certifier	1 0	Δ	29c. Licens	e number	29	d. Date signed (Mon	th, Day, Year)
	. *		Klem G.	Nealon,	an ·1)	. D	23127 (MI	))	April	28, 2005
	20		30. Name and address of person who con						_	
	V	10	Kevin Nealon, M.I	0. 5530 Wiscons		enue #92	5 Chevy	Chase, Ma	ryland 20	815-4308
	Sta Registi		31. Date filed (Month PR Year) 9 20	05 Been S		de				

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year AYlor 0100 Ames LAWRENCE 2005 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number 6. Sav 7. Age (In yrs, last birthday) If U Burne olew If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Country) LOUISIANN & **Funeral** 120-52-1266 Months Days Hours 12 M 2 □ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "neturel", or Items 23a or 28a-f shov eny Injury or other traumatic event, Ir e Medical Examiner must be notified at Odenton 1 ☐ Yes 2 ☑ No **Funeral Director** Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Never Married 2 ☐ Married ☐ Yes 2 No f Yes, Give 1□ Yes 2☑ No Specify: Specify: Black Be Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Sanitation Dept ath 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ unk. Unk-19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pettie- daughter 50nia 546 Retreat Apt. F Odenton, MO 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-29-05 Catonsville, mo 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 21. Signature Juneral Service Licensee 22. Name and Address of Facility GORY P. MORCH FIH 270 Fredhilfon RSS BALTO, MD 212,39 Approximate Approximate Approximate Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Heart Disease Examiner Physician/Medicai Examiner To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit or Attending Physicien: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ylellitus Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Medical Certification: To Be Completed 24a. Was an autopsy performed? TLY Yes 2 XING 1 Tes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 Tes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Deputy

cause of death (Item 23a) (Type, Print) MY

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar 31. Date filed (Mon:

Day, Year)

2

9 2005

			1 - For State Registrar	State of I	Maryland	-	artmen rtificat				ental Hy	gien Reg. Ne	2000	14625
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	Funeral		5. Social Security Number	6. Sex 7. 1 √ M 2 ☐ F	Age (In yrs. la		If Under	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th		nplace (State or Foreign
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Baltimore,	permit. Pages 1 and 2 Department of Health s Importent: If item 27 it any Injury or other tra once.		1 ☐ Burial 2 ☑ Crematio	on 3 Removal from Sta	ate Ce	metery, crei	natory or o	ther plac					ocation - City or I	
Ħ	artme orteni Injury		' 4 ☐ Donation 5 ☐ Other  21. Signature of Fugeral Servi		HIL	22	. Name an	d Addres	s of Facilit	v			son, Mar	yland
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State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year WALTON RA CHEL 13:10 APRIL 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MOPKINS BAYVIEW BALTIMORE CITY JOHNS BALTIMO AL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Nov 8, 1941 9. Birthplace (State or Foreign **Funeral** Days Hours 1□M 2QF Virginia 63 Director 578-56-1544 Yrs Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?? is marked other than "natural", or Items 23a or 28a-f show traumatic event, its Medicul Exarta er must be notified at 1 TYes 2 □ No Director MD Howard Columbia 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21045 USA 7143 Staghorn Path Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No 4 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker Own Home permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, important: If Itam 27 is marked other any injury or other trainment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Franklin Caldwell Lucille Lucreta Snider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7143 Staghorn Path Columbia, MD Ray Walton - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State , crematory or other place) cemetery 1 Burial 2 Cremation 3 Removal from State Mount Clinton Cemetery 4/26/05 Harrisonburg, VA \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Cicenses McMullen Funeral Home, Inc. 5784 Greenmount Koad Harrisonburg, VA 22802 Approximate Interval Between Onset and Death mmediate Cause (Final PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OBSTRUCTIVE LUNG DISEASE WEEKS CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð ARTERY CORONARY DISEASE 1XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 1 Yes 2 R No 1 Yes 2 □ No Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ≰Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To SIL 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD ava 0 33*709* 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAYNEW, 4940 EASTERN AVE, BALTIMORE JUHNS HOPKINS PARAKH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 9 2005 Registrar

amend item#ac.perma, 8842, 4/29/00 Lt Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 10:007 **Physician** 26 ONN Williams 2005 S 04 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death N/A Examiner RVE 2501 MOORE BACTIMONE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 150 M 2□ F 53 214-58-5873 May 29, 1951 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1t☑Yes 2□No Maryland Directo N/ABaltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 2501 Moore Avenue USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 7/1-77 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 11 1 Yes 2 □ No 74 - 77 Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ∏ No Specify. Specify: Completed by White 3 ☐ Widowed 4 ₹ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Minor League Umpire Baseball League 2 yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ John William Williams Jr.
19a. Informant's Name/Relationship (Type, Print) Della Kathryn Mattheis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Williams, IV (Son) 2438 Trace Oak, San Antonio, TX 78232 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 4/28/2005 Baltimore, Maryland 21. Signature of Funeral Service Vicen 22. Name and Address of Facility Martin D. Lawson awson Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARCINOMA Immediate Cause (Final disease or condition resulting in death) & months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yee 2□ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes

**Physician** /Medical Examiner or Attending Physicien: The law requires that the death certificate be executed

end

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peen hes

certificate

Director: After

death.

To the Hospital within 24 hours e

Division of Vital Records, P.O. Box 68760,

Department of important: if it any injury or o once.

**Funeral** 

Director

Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or Items 23a or 28e-f show

Baltimore, Maryland 21215-0020

of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-f show other treumetic event, the Medical Examinar must be notified at

Examiner ettending physician for use as the burie Physician/Medical use funeral director, page 2 should be detached 5 Completed Be Certification: To the completely filled in by Medical

27. Manner of Death

1. Natural

2 Accident

4 🗆 Homicide

31. Date filed (Month

3 Suicide

29a. Certifier (Check only one)

5 Pending

investigation

6 Could not be determined

R2

State Registrar 29b. Signature and title of certifier

9 2005

29c. License number

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

and manner stated.

man, 32. Signature

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Baltimore
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Box 68760,
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		For State Registrar	State of Ma	•	eparime <i>Certifica</i>			vientai Hy	giene Reg. No.	005	14628
		Decedent's Name (First, Middle, Last)						2. Date of D		Year	3. Time of Death
Physici: /Medic		Donald Wes		nters				April	26	200	
Examin	er	4a. Facility Name (If not institution, give s  North Alud  5. Social Security Number 6. Sex	d Hosp	ml (In yrs. last birti	6		Location of Death  Location of Death  Location of Death  If Under 24 Hrs.		An	ne An	
Funeral Director			M 2□F		rs. Month:		Hours Min.	(Month, D	ay, Year)	942 Mai	ountry)
		Usual Residence of Decedent	\\					11011			
the Marylar 28e-f show	5	10a. State 10b. County		10c. City, Town							10d. Inside City Limits 1 √2 Yes 2 □ No
the N 28e-1	Director	MD Anne Aru  10e. Street and Number	ndel	U	denton 10f. 2	ip Code			10g. Citize	en of What Co	ountry?
h with 23a or	ם	985 Patuxent Road					21113			USA	
r deat	Funeral		2. Was Decedent Ev Armed Forces?		13. Was Dec	edent of H	ispanic Origin? (S an, Mexican, Puert	pecify Yes or N to Rican, etc.)	0- 14	4. Race - Ame Black, Whi	
should be filed within 72 hours after death with the Maryland and Mental Hygiene. In arked other then "neturel", or items 23a or 28e-f show unasted other then "neturel", or items 20a or 28e-f show unastic event, it a Madical Examiner is until to instilled at	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates:			2 <b>∏</b> No	Specify:				White
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al Hyg	Bec	17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne (First, Middle	e, Maiden S	Sumame)	
outd b Ment Ment arkec	၉	Freeman Henry Win						Va. Ro			
d 2 sh th and 7 Is m treum		Jean Marie Robinet					and Number or Ru Road, Ode				Zip Code)
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if I lem 27 is marked other then any injury or other freumatic event, ITE Magnee.		20a. Method of Disposition	te/Sister	20b. Place of	Disposition (N	ame of		Date	_	ation - City or	r Town, State
Pages nent of nt: #1		1 ☐ Burial 2 🖾 Cremation 3 ☐ R  1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1	y, crematory`or .runde1		atory Ap	r 30, 2	005	Odentoi	n, MD
permit. Departminimporte any inju		21. Signature of Funeral Service License	90				ss of Facility		-		
2 8 2 E 8 8		Domenico am	nodeo MOI				olis Roa			MD 211	
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused t ne cause on each line	he death. Do n	not enter the m	ode of dyin	ig, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	10	consequence of		eficie	سع کہا ا	Lrome			
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2 11 12 11											
tificate ng phys as the	hysiclan/Medical										
ath cer ttendir or use	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 Live birth 2	Fetal death			,		23	3d. Date of de Month	blivery Day Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at t 9☐ Unknown	ime of death	5 Other (	specify) _					
that I	by Ph	Part II. Other significant conditions con	ntributing to death bu	t not resulting in	the underlying	g cause giv	en in Part I.	23e. Did	tobacco us	e contribute t	to the cause of death?
law requires law segments as been signed as should be								1	Yes 2	]No 3□P	robably 4 Unknown
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The cate h	Co							per 1 Yes	formed? 2.5 No	death?	s 2 No
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g Phy arthis eral d	H	27. Manner of Death	28a. Date of Injury (Month, Day	/ 28b. T	tpatient 3 1	28c. Injur Wor	4 C Ruising r	dome 5 Res 28d. Describe			эспу)
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To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	one)	sicien: To the best o ner: On the basis of and manner stat	'Ari							
To the To the comp	M	29b. Signature and title of certifier	12		2	29c. Licens	e number		29d. Date	signed (Mon	th, Day, Year)
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10		30. Name and address of person who co	ompleted cause of de	ath (Item 23a) (	(Type, Print)	An	undel	Hosni	ta/		
	ate	31. Date filed (Month, Day, Year) APR 2 9 2005	32. Registra	r's Gnatur	arte	- 1,10	37.007	יווןנייון	, , , ,		
Regist	rar	APR 2 9 2005	BERRIAS-	and and							

			State of Maryland / Dep	artment of Health and Mental Hy rtificate of Death	•
	9 -		Decedent's Name (First, Middle, Last)	2. Date of De	
	Physicia /Medic		Frederick Eugene Waddell	April	26 2005 7:08P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			15401 Blue Willow Lane	Accokeek	Prince Georges
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F	Months Days Hours Min. (Month, Da	y, Year) Country)
	Director		241-48-3477 Fig. 69 Yrs. Usual Residence of Decedent	July 1	3, 1935 Wilmington, NC
	nyland how		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	e Ma sa-1 s	ctol	MD Prince Georges Accokeek		1 ☐ Yes 2v No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	sath v	Funeral	15401 Blue Willow Lane 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20607	United States  14. Race - American Indian,
	ter de	'n	Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
920	urs at	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No korean If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 📉 No Specify:	Specify: Black
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Z	E E E	ဥ		ing Address (Street and Number or Rural Route Numb	
	12 h a		Arlene Y. Waddell Wife 15401	Blue Willow Lane, Accoke	eek, MD 20607
Jre,	es 1 and of Healt fitam 2 r othar		20a. Method of Disposition 20b. Place of Disposition cometary, cre	osition (Name of Date matory or other place)	20c. Location - City or Town, State
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Baltimore,	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Licenson 2	2. Name and Address of Facility Lee Fune	cal Home, Inc.
_	0.0 <u>7</u> € 01			633 Old Alexandria Ferry	
	e 65		23a. Pant: Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	- \	rrest, Approximate Interval Between Onset and Death
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Вох	death s atter d for u	Physician/Med	in the past 12 months?  1 Vac 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	Month Day Year
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Vita	Physician: The this certificate ral director, pages	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only of Other	
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lon	nding Phi th. :: After thi s funeral	atlor	1 Natural 5 □ Pending (Month, Day Year) Injury 1 Accident investigation	Work? M 1 □ Yes 2 □ No	
Division	or Attandi after death. Diractor: A in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f. Location (	Street and Number or Rural Route Number,
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	To the Hospital or Attanding within 24 hours after death.  To tha Funaral Diractor: After completely filled in by the fune	Mec	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
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	. 0		30. Name and address of person who completed cause of death (Item 23a) (Type,		
	10		Eugene C. Taylums 510		9442 em C
· 31	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		
40	Registi	<u> </u>	APR 2 9 2005 Seem & A	Joseph	
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ORIGINAL

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F			ene . No. 200	5 11600	
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle DONNA) 4a. Facility Name (If not institution)			WP   Gr	r Location of Dea		Day Year 4 , 2005	11:31 bw	
	Funeral Director		THE JOHNS HOPKINS 5. Special Security Number 218-12-3624	6. Sex 7. Ag	e ( <i>In yrs. last birthday</i> , 31 Yrs.	BOLTIMON If Under 1 Year Months Days			<sup>(ear)</sup> 9. E	Birthplace (State or Foreign Country) Ohio	
	e Maryland ta-f show	ctor	Usual Residence of Decedent  10a. State  MD  Anne	e Arundel	10c. City, Town or L	ocation Pasadena			10d. Inside City Limits 1 ☐ Yes 2 💆 No		
	th with th	Funeral Director	301 Cloverhill	Road		10f. Zip Code	211		p. Citizen of What US	-	
920	s 1 and 2 should be filled within 72 hours after death with the Maryland I Health and Mental Hygiene. I then the marked other than "neturel; or Items 23a or 28a-f show item 27 is marked other than "neturel; or Items 20a or 28a-f show other treumatic event, the Michael Examiner must be neithed at		11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	If Yes Give		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ai Black, W Specify:	merican Indian, hite, etc. white	
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Baltimore,	t. Page rtment o rtant: if njury or		1 ☑Burial 2 ☐ Cremation  1 ☑Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S	(pecify)	Loudon F	Park Cemet	tery Apr	il 28, 200	· ·		
Ba	permi Depa Impo any id		23a. Part1. Enter the disease, o	complications that caused	la, Jr.	22. Name and Addre Charles I 1501 E. I	. Steve Fort Ave	ns Funeral nue, Balti nc or respiratory arres	Home, I	Approximate	
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),		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	. AONTIC	EART FAILUR a consequence of): STENDSIS a consequence of):	4		12 DAYS			
ox 68760,	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	IF FEMALE:	d	of pregnancy				23d. Date of	Alivan	
.O. Box	that the death ed by the atter detached for u	hysiciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown		□Ectopic pregnanc □ Other (specify) _	У		Month	Day Year	
Records, P.	law requires that the as been signed by th 2 should be delache	by	Part II. Other significant conditi	ons contributing to death b	out not resulting in the	underlying cause giv	ven in Part I.			to the cause of death?  Probably 4 Munknown	
	i: The law ricate has be page 2 sh	Completed						24a. Was an autopsy performe 1 □ Yes 28	id? prior death		
on of Vital	ding Physicien: The th. After this certificate hir funeral director, page	tion; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pendial invest	Hospital: 128 Inpatience 28a. Date of Inju (Month, Da	ent 2 ER/Outpatie	of 28c. Inju	ner: 4 Nursing	eath (Check only one) Home 5 Resident 28d. Describe how	ce 6 □Other (S	pecify)	
Division	el or Attending s after death. il Director: After od in by the fune	Certification;	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of In	jury - At home, farm, st tc. (Specify)			28f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,	
	To the Hospitei or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical (	(Check only 2 Medical one)	ng Physician: To the best Examiner: On the basis of and manner st	of examination and/or in	nvestigation, in my o	opinion, death occ	turred at the time, date	and place, and o	lue to the cause(s)	
	or With	2	29b. Signature and title of certific Den Oc		M, M.O	29c. Licens	- 000		Date signed (Mo		
K	21		30. Name and address of person	BOIL M.D. G	OO NODEL IN	OLFE STARE	- Estil	HORE MANYL	AND 212	?7	
:	Sta Regist		31. Date filed (Month, Day, Year APR 2	9 2005 32. Registr	rar's Signature	pede					

			1 - For State Registrar	State of Marylan	•	artment of F		-	giene Reg. No.	2005	14631
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	Hazel Louise	Washa	baugh		2. Date of De Month APRIL	Day	Year 2.005	3. Time of Death
	Examin		4a. Facility Name (If not institution, give s Union Memorial H			4b. City, Town, o Baltin		ith		County of Deat	
	uneral		5. Social Security Number 6. Sex	*	last birthday) Yrs.	tf Under 1 Year Months Days			rth	9 Birt	hplace (State or Foreign Unitry) Linois
D			Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
ө Магу	Sa-f sh uffied.	ctor	Maryland N/A	E	Baltimo	ore					1 X Yes 2 ☐ No
with th	Sa or 21	i Directo	10e. Street and Number 3622 - 5th Stre	et		10f. Zip Code 212	225		-	zen of What Co U.S.	untry?
be filed within 72 hours after death with the Marylend	Dependent of result and wenter regions in the major of teme 23e or 28e-f show any injury or other treumatic event, the Medical Examinational be collided at once.	by Funerai		12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H It Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (	Specify Yes or No rto Rican, etc.)	)-	14. Race - Ame Black, White Specify: Wh	e, etc.
within 72 ho	than "natur	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired emaker	during most of w	orking		nd of Business/ Home	Industry
should be filed	nrked other	To Be C	17. Father's Name (First, Middle, Last) Philip	Greiber				ame (First, Middle a Dubins		Sumame)	
end 2 sho	n 27 is ma	ľ	19a. Informant's Name/Relationship (Ty William Washabaug			ng Address <i>(Str</i> eet Versaille:		Towso		r Town, State, 2 aryland	•
ages 1	t: If iter		20a. Method of Disposition  1  Burial 2  Cremation 3  F	temoval from State	emetery, crei	osition (Name of matory or other place Crematory	·	Date 6/2005		cation - City or	Town, State Maryland
permit, Pages 1	Importen any injury once.		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		22	2. Name and Addre	ss of Facility	Gonce Fu	nera	l Servi	ce, P.A.
	2 2 2 2		23a. Part1. Enter the disease of comple	ications that caused the death		T-17				re, Mar	yland 21225 Approximate
//\	ysician ledical aminer	1986	shock, or heart faiture. List only or Immediate Cause (Final disease or condition resulting in death)	a. SEPSI  Due to (or as a consequence)	5						Interval Between Onset and Death 38 DAYS
cate be executed	physicien end s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence).							
The law requires that the death certificat	been signed by the attending phy should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)	1		2	23d. Date of del Month	very Day Year
requires that	n signed b uld be deta	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.				the cause of death?
The law re	n. After this certificate has bee funeral director, page 2 sho	Completed						24a. Was auto perfo 1  Yes			topsy findings available completion of cause of
Physicien:	s certific	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 ☑npatient 2 ☐	ER/Outpatier	nt 3 DOA Oth		eath <i>(Check only o</i> Home 5 Resi		Cother (See	W
Attending Phy	ain. r: After this e funeral c	H-	27. Manner of Death  1 DNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur Wor	y at	28d. Describe			шу)
Lel or Atte	Within 24 hours effer death.  To the Funerel Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str y)	reet, factory, office		28f. Location ( City or To			ral Route Number,
Hospi	Funer Funer etely fill	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
To the	To the	Me	29b. Signature and title of certifier			29c. Licens				e signed (Monti	
19			30. Name and address of person who co	3	△ D 1 23a) (Type.		138946	- E37	APR	25	, 2005
1			PARUL AGARWAL IN	10 201 EA	ST UNI	VERSITY P	'ARKWAY	BALTIMO	RE,	MARYLAK	10 21218
	Sta Registr		31. Date tiled (Month, Day, Year) APR 2 9 2005	32. Registrar's Signa	ture	le le					

05-2924 B.K.S KAITLYN I. YOON

	ian	Decedent's Name (First, Michael Control of the	ddle, Last)				ertificate of			2. Date of Dea Month	ath Day	Year	3. Time of Death
Medi/ Examir	cal	Kaitlyn I  4a. Facility Name (If not institu		ing Y street and nu			4b. City, Town,	, or Location		APRIL		2005 unty of Death	4:08 P
	П	JOHNS HOPKIN	IS HOS			last hirthda		IMORE of the state		Date of Bird		0.014	
uneral irector		5. Social Security Number 212-59-6188		M 2⋤F	7. Age (in yrs	s. last birthday Yrs.	Months Day		Min.	B. Date of Birt (Month, Da Aug 1	, Year) 3, 200	0 Mary	place (State or Fore intry) 1and
Mo ==		Usual Residence of Decedent  10a. State 10b. Cour	nty		10c. C	ity, Town or L	_ocation		<u> </u>				10d. Inside City Lim
a-f sh	ctor	Maryland How	ard			Clarks	sville						1 ☐ Yes 2 🔀 İ
or 28 be no	Funeral Director	10e. Street and Number					10f. Zip Code					of What Cou	intry?
ns 23g	eral	7205 Wolvert			edent Ever in t	U.S. 13.		L029	rigin? (Spec	ify Yes or No	U.S	·A.	ican Indian.
important: if itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, it a Madical Examinat must be notified at 2008.	þ	1 ☑ Never Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divord	larried	Armed For 1 Yes If Yes, Given Year or D	orces? 2⊠No ve		. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☒ N			ican, etc.)	}	Black, White	
"natur	Completed	15. Decec (Specify only hig	dent's Educ thest grade			16a. Deci (Giv	edent's Usual Occ e kind of work don DO NOT use reti	upation e during mos	st of workin	g	16b. Kind o	of Business/Ir	ndustry
Than Than	ошо	Elementary/Secondary (0-12 n/a	2)	College (	1-4or 5+)	me.	n/a	100)			n	/a	
othe vant,	Be C	17. Father's Name (First, Midd	lie, Last)					18. Moth	er's Name	First, Middle,		<del>'</del>	
arked	10	Sam Yoon							ssand				
7 is n traun	1	19a. Informant's Name/Relation Sam Yoon (I	onship <i>(Ty)</i> Cathe			1	ling Address (Stre Wolverto				-		
item other		20a. Method of Disposition			20b.	Place of Disc	osition (Name of	-	Da			on · City or T	
ant: if ary or	1	1 A Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		emoval from	State C1	restlav ardens	ematory or other p √n Memori	la1	4-30-	-2005	Marrio	ottsvi	11e, MD
importa any inje once.		21. Signature of Funeral Serv	ice License	98		1 1	22. Name and Add	ress of Facili	itu				and_2104
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edical miner	cal Examiner	Immediate Cause (Final disease or condition	ist only or	Due to	<sub>each line.</sub> licatio	ons of equence of):	nter the mode of d						Approximate Interval Between
ysician and mile burial-transit	cal	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ist only on	Due to	each line.  licatio (or as a conse	ons of equence of):  equence of):  equence of):  equence of):	nter the mode of d	ying, such as			rest,	Date of deliv Month	Approximate Interval Between Onset and Death
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DHMH 17 Rev 1/2001

APRIL

EDWARD YOUNG

		1 - State Registrar  1. Decedent's Name (First, Middle, Last)	State of Maryland	d / Depa		Health and	-	giene Reg. No.	2005	3. Time of Death
Physicia /Medic	al		iam Joseph Za	chik	4b. City. Town.	or Location of De	April	25 <sup>Day</sup> 20	Year 005	11:22 PM
Examin Funeral	er	12420 Over Ridge F 5. Social Security Number 6. Sec	Road		Poto  If Under 1 Yea  Months Days	mac	rs. 8. Date of Bi	Mor	ntgomer	y lace (State or Foreign
Director	_	146-05-0444  Usual Residence of Decedent  10a. State  10b. County	72	Yrs.	ocation		March 3	30, 191		Od. Inside City Limits
with the Ma	Directo	Maryland Montgome  10e. Street and Number		Pot	Omac 10f. Zip Code	2051			of What Cour	
permit. Pagas 1 and 2 should ba filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23s or 28s-f show any injury or other treumatic event, I'm Modical Eractiner must be notified at once.	Completed by Funeral Director	12420 Over Ridge F  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	(OAQ 12. Was Decedent Ever in U. Armed Forces? 1	ł			(Specify Yes or No erto Rican, etc.)	)- 14. I	ed Stat Race-Americ Black, White, Brify: Whi	an Indian, etc.
within 72 hou ane. then "nature be Medical E	mpleted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)		dent's Usual Occi kind of work doni DO NOT use retir		working		f Business/Ind	
d 2 should be filed within 72 hours aft th and Mental Hygiene. Tr is marked other then "naturel", or treumatic event, it e Muulcal Erami	To Be Co	17. Father's Name (First, Middle, Last)  Valent Zachik	4				lame (First, Middle ne (Not		name)	
1 and 2 sho Health and em 27 is ma ther treums		19a. Informant's Name/Relationship (Ty. Albert Zachik/Son  20a. Method of Disposition		12420	Over Ri	dge Road	Rural Route Numb  Potoma  Date	c, Mar		20854
permit. Pagas 1 ar Department of Hea Important: If Item i any injury or other once.		1 \( \mathbb{R}\) Burial 2 \( \subseteq \text{Cremation} \) 3 \( \mathbb{R}\) 4 \( \mathbb{D}\) Donation 5 \( \mathbb{D}\) Other (Specify) 21. Signature on Funeral Service (Icense)	Ce	metery Ro	Name and Add	ess of Facility Pumphre	ril 30, 005 y Funeral , Bethesd	Coloni Home/	a, New	Jersey da-Chevy
/Medical be executed // // // // // // // // // // // // //	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or firmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Congestive  Due to (or as a consequence of the cons	Heart		_	ac or respiratory a	illest,		Approximate Interval Between Onset and Death
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aw requires is baen sign 2 should be	Completed by Pt	Part If. Other significant conditions con Hypertension	ntributing to death but not resu	Ilting in the u	nderlying cause g	iven in Part I.		Yes 2⊠No	3 ☐ Prob	e cause of death?  ably 4 Unknown  by findings available inpletion of cause of
	Be Com	25. Was case referred to medical examiner?				26. Pface of D	perfo 1 ☐ Yes Death (Check only	ormed? 212 No	death? 1 ☐ Yes	
inding Physiath. rr: After this re funeral di	၉	1 X yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	lospital: 1   Inpatient 2   1   28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o fnjury	f 28c. Inj		Home 5 X Res 28d. Describe			()
To the Hospital or Attending within 24 hours after death. To tha Funerel Director: After completely filled in by the fune	al Certification;	3 Suicide 4 Homicide  6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify sician: To the best of my known	')			City or To	wn, State)		Route Number,
To the Hos within 24 h To tha Fur completely	Medical	(Check only one)  2 Medical Examination (Check only one)  29b. Signature and title of certifier	ner: On the basis of examinat and manner stated.	ion and/or in	vastigation, in my	opinion, death or	curred at the time,	date and place 29d. Date sign	gned (Month, I	the cause(s)  Day, Year)
01		30. Name and ad ress of person who co			Print)	190 l	W Washi			26,2005
Sta Registr		Alexander C. Chest 31. Date filed (Month, Day, Year)	32. Registrar's Signal			venue, N	.w. wasni	ng con,	ν.υ.	20016

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Geraldine Mary Zambetti 2:05 p.m. M April 26, 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Burtonsville Holy Cross Nursing Home & Rehab. Montgomery County 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2**X**F Director 181-30-8329 March 21, 1937 Pennsylvania Usual Residence of Decedent s filed within 72 hours after death with the Maryland Ul-lygiene. Other than "natural", or Items 23a or 28a-f show ont, the Macifical Examination and be confilled at your, 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 No Maryland Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20723 U.S.A 7930 Helmart Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Tes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Education Elementary/Secondary (0-12) College (1-4or 5+) Instructional Assistant 12 nit. Pages 1 and 2 should be filed artment of Health and Mental Hygi ortant: If item 27 Is marked other injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Felix Maminski Katherine Poch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7930 Helmart Dr. Laurel, Maryland 20723 Husband Mr. Angelo Zambetti 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department o important: If any injury or once. 4 □ Donation 5 □ Other (Specify) 05/03/2005 Mechanicsburg, Pennsylvania Gate of Heaven 21. Signatylle di Funeral Selvice Licensie MO1293 22. Name and Address of Facility Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the disease, or com-shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final metastatic endometria **Physician** advanced disease or condition resulting in death) 18CLYS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending p for use as use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ailure renai 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 P No 2 1 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 130034726 April 26, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JASMINE CHEN GATTI M. D Oi Bethesda Massena 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registra

		1 - State Registrar	State of	Maryland /		rtment of F tificate of t		and Me		giene Reg. No.	4000	1463
Physici	an	1. Decedent's Name (First, Middle, La	•						2. Date of De Month	Day		
/Medic	cal	ALMETA S. A 4a. Facility Name (If not institution, giv	KERS	nher)		4b. City, Town, or	r Location o		April	-	2005 County of Dee	12:00 P.
Examin	ier	1220 East West				Silver				40.	Montgo	
uneral		5. Social Security Number 6. S	өх	7. Age (In yrs. last	birthday)	If Under 1 Year Months Days			B. Date of Bin	th v. Year)	9. Bir	rthplace (State or Foreig
irector		577-42-0678 Usuel Residence of Decedent	□M 2⊠F	90		Months Days	110013		9-26-1			tsboro, N.C
W H		10a. State 10b. County		10c. City, To	own or Loc	ation						10d. Inside City Limits
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d other then "naturel", or items 23s or 28s-f show event, the Medical Examinar must be notified at	by Funeral Director	10e. Street and Number	•			10f. Zip Code	# 70			10g. Citi	izen of What C	ountry?
s 23a	rai	1220 East West			40.14	( ) ( ) ( ) ( ) ( ) ( )			4 14 - 11		ted Sta	
r Item	F	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed For	dent Ever in U.S. ces? 2-⊡ No		as Decedent of H Yes, specify Cuba	in, Mexican	, Puerto R	ican, etc.)	-	14. Race - Ame Black, Whi	
o. Je	þ	3 <sup>™</sup> Widowed 4 Divorced	1 ☐ Yes If Yes, Giv Year or Da	e Tites:	1 (	☐Yes 2√2No	Specify:				Specify: Bla	ack
natu dical	Completed	15. Decedent's Education (Specify only highest graduation)		16	6a. Decede	ent's Usual Occup- ind of work done of O NOT use retired	ation during most	of working	7	16b. Ki	ind of Business	
then	m du	Elementary/Secondary (0-12)	College (1	-4or 5+)	irte. Do	O NOT use retired						
other th	ပိ	12th 17. Father's Name (First, Middle, Last,	)		<u></u>	-		rvis r's Name (	Or First, Middle,	Maiden	Governm Sumame)	ent
rked Ic ev	To Be	William Stroud					Lena	Dor	sett			
item 27 is marked other to other treumatic event, in		19a. Informant's Name/Relationship (	* .	1		Address (Street						Zip Code)
: 5:		Ernestine Bartle	y/Daugh			4th St.,			100			
or of		20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐		Nuto		ition (Name of atory or other plac		Da			ocation - City or	
Importent: any injury c		<ul> <li>4 □ Donation 5 □ Other (Specifical Service Lice)</li> <li>21. Signature of Funeral Service Lices</li> </ul>	11 1	Linco		emetery Name and Addres		-16-0			tland,	
Importent: If item 2 any injury or other once.		21. Signatur divulleral Service Lites	Fullis	in Vall	//	425 Maryl				_	ol Mort	
		23a. Pan 1. Enter the disease, or m	lications that ca	aused the death. D	1						, 2,0,	Approximate
sician		shock, or heart failure. List only Immediate Cause (Final disease or condition	ATILIT		min.	REWAL A	Dulk	2-				Interval Between Onset and Death
ledical		resulting in death)	Due to (	or as a consequence		Ellie II	"I/UU ¥					4111-60
aminer	_	Sequentially list conditions,	HYPER	TONSWEG	MEDIC	MOULE	RDIS	145				MEANS
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	/ Due to (	or as a consequenc	CB OT):							
n and ial-tra	Exar	that initiated events resulting in death) Last	c. Due to (	or as a consequenc	ce of):							
physician and the burial-transit	dicail		_ d									
ng ph as th	Medi	IF FEMALE:										- 2002
attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi	come of pregnancy rth 2 Petal dea		ctopic pregnancy				2	23d. Date of de	livery Day Year
by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9☐Unkno	ant at time of death wn	5 □ (	Other (specify)						52,
igned by be detai	y Ph	Part II. Other significant conditions of	ontributing to de	ath but not resulting	g in the und	derlying cause give	en in Part I.		23e. Did to	obacco u	se contribute to	o the cause of death?
should be	d be	ADRIC STENESIS							101	(es 2)	Mano 3□Pr	robably 4 Unknow
S C/	Completed by								24a. Was		24b. Were au	utopsy findings available completion of cause of
certificate has rector, page 2	E O									med? 22 No	death?	2 No
certificate rector, paç	Be (	25. Was case referred to medical examiner?					26. Place	of Death (	Check only o			
(A) TO	ျ	1 ☐ Yes 2 ☐ No			Outpatient		4 🗀 1901	-	_		Other (Spe	icify)
	tion	27. Manner of Death  1		f Injury 28t h, Day Year)	D. Time of Injury	28c. Injury Work M 1 □ `	/at <br Yes 2.∐N		d. Describe h	now injur	y occurred	
After	65	3 Suicide 6 Could not b		of Injury - At home, ig, etc. (Specify)	, farm, stree			100				ural Route Number,
octor: After	fice		buildir	ig, etc. (Specify)					City or Tow	m, State,	)	
in b	Certifica	4 ☐ Homicide determined								cauco(e)	and manner as	a stated
Funeral Di	dical Certification:	29a. Certifier 1 Certifying Ph	ysician: To the niner: On the ba and mann	best of my knowled sis of examination er stated.	dge, death o and/or inve	occurred at the time estigation, in my or	ne, date and pinion, deatl	n piace, and h occurred	d due to the d at the time, d	date and	place, and due	e to the cause(s)
Funeral Di	Medical Certifica	29a. Certifier  (Check only)  1 Certifying Photogram 2 Medical Example	niner: On the ba	sis of examination	dge, death o and/or inve	estigation, in my op	oinion, deatl	place, and place, and place and plac	at the time,	date and	place, and due	e to the cause(s)
_ = _		29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	niner: On the ba	sis of examination	dge, death o and/or inve	estigation, in my or	oinion, deatl	place, and	at the time,	date and 29d. Date	place, and due	to the cause(s)
Funeral Di		29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	niner: On the ba	sis of examination er stated.	and/or inve	29c. License	oinion, deatl	place, and occurred	at the time,	date and 29d. Date	place, and due	to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U [] 5 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2005 April 15, **Physician** 10:40 A.M Addie Louise Akers /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Year) Jan. 14, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 1 F Hours Min Yrs. 89 1916 Virginia Director 219-38-1434 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "naturel", or Itams 23e or 28e-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral, or Itams 23a or 28a-f shov Examiner must be notified at 1 AYes 2 No Director Md. Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 USA 24 Boxwood Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specity: Specify: White 3 Widowed 4 Divorced 27 is marked other than "natur traumatic event, I're Modical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Critzer Grace Reed Luther ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l daughter 24 Boxwood Rd., Annapolis, Maryland 21403 Ariel Akers-Brown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 0 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Metropolitan Crematory 04-17-05 Alexandria, VA. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Furral Service Licensee 6512 N.W. Crain Hwy., Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ischemic cardiomyopathy 1 day resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Dua to (or as a consequence of) Completed by Physician/Medical Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No ō Month 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 🗌 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 XNo 1 Yes al director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Olher (Specify) 1 ☐ Yes 2 🙀 No Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident investigation hours after deat 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 \ Homicide To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29b. Signature and little of certif

State

31. Date filed (Mark, Day, Year) 22. Registrar's 3

30. Name and address

2. Registrar's Signature.

of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death <sup>Day</sup> 2005 **Physician** JOHN **ALVIS** APR 20 6:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 10XM 2□ F Director 459-64-8250 Apr. 1926 Texas Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or iteme 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2√☐ No Directo Virginia FAirfax Vienna 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2025 Spring Branch Drive 22181 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married 1 X Yes 2 No 1949-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify δ White 3 ☐ Widowed 4 ☐ Divorced 1979 leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Compl College (1-4or 5+) Elementary/Secondary (0-12) 5+ Officer - Rear Admiral U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be lift Depertment of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. Be Vestus Alvis Lissie Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois J. Alvis/Wife 2025 Spring Branch Drive, Vienna, Va. 22181 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Apr. 22, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia \* 4 ☐ Donation 5 ☐ Other (Specify) 2005 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MONEY & KING FUNERAL HOME, INC. 171 W. Maple Ave., Vienna, Va. 22180 23a. Part 1. Enter J e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) PNEUMONIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician ched for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a ld be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 **X**No 2 □ No 1 Yes 1 Tyes Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ **X**0 1 ☐Xpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Death 28b Time of 28c. Injury at Work? After 1 XXatural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö within 24 hours e To the Funeral I 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number of certifier 29b. Signature and litt April 21, 2005 0101236903 (VA) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 T.W.KINDELAN MC USN 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 2 9 2005

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jennifer Burkett Month 04/14/2005 Year 11:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6125 Fox Lane Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country, MD Funeral 8. Date of Birth (Month, Day, Year) 1 □ M 2 XF Yrs. Director 218-68-2337 41 10/04/1963 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28e-f show other treumatic event, the Medical Exercit error teat be notified at Director Wicomico 1 Yes 2 No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5 6125 Fox Lane Items 23e 21801 Completed by Funeral USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2X No White Specify 3 Widowed 4 Nivorced 'naturel' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Equestrian Instructor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Berry H. Nall Shirley Koontz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Cooke (sister) rtment of Health 13701 Primrose Ct. Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ō Cape Henlopen Crem, 04/18/2005 Frankford, DE Injury \* 4 ☐ Donation 5 ☐ Other (Specify) permit.
Dep rtm
Importe
any inju 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William Street Berlin, MD 21811 23. Part 1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Kespiratory toulure disease or condition resulting in death) /Medical **Examiner** Parieto-occipital Astrocytoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physicien: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death Check on one examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X esidence 6 Other (Specify) P 1 Yes 2XNo 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Accident investigation after death 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D58755 April 15,2005 ddress of person who completed cause of death (Item 23a) (Type, Print) HEALTHWAY DRIVE, BEZUN, MD 21811 State' Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Control   Cont				1 - For State Registrar	State of Maryla		ent of Health ate of Deat			jiene leg. No.?	St. Land	11.51.1
Coastal Hospice At The Lake   Salisbury   Wicomico   Single   Si		/Medi	cal	Carl Franc	cis Barrett	14.0	-		Month	Day 15 20	005	3. Time of Death 0615 A A
Part   Part		Funeral	ner	Coastal Hospice 7  5. Social Security Number 6. S	At The Lake	s. last birthday) If Un	Salisbury	der 24 Hrs.	(Month, Day	Wicom	9. Birthplac	ce (State or Foreig
Secondary Color Proposed State State Company (Color State State Colored State State Colored State State Colored State State Colored State State Colored State State Colored State State Colored Stat		2 .	or.	217-62-7814  Usual Residence of Decedent  10a. State 10b. County	38	city, Town or Location			Sept. 7	27,1966	MD	1. Inside City Limits
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Physician Medical Examiners  Physician Medica	more	rages intent of Hint: if italian		1X Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crematory	or other place)	1				1, State
Physician / Moetical Examiner    Part   Description	Balti	Departm Departm Importa any inju				22. Name	and Address of Fa	cility The	Burba	ge Fund	eral h	łome
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Continuity of the properties	<del>=</del> =	certif	00	examiner?	Hospital:	_	Othor					
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H.5 DAVID CHALL, WW COASTAL HOSPIE P.O. Bix 1733 Salisbur, MD 21802	7	in 24 hour ha Funara pletely fills	edical	29a. Certifier (Check only one)  Certifying Ph 2 Medical Example		nowledge, death occurr ation and/or investigati	ed at the time, date on, in my opinion, d	and place, a leath occurre	nd due to the ca	ause(s) and man ate and place, ar	ner as state nd due to the	id. e cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  OAVID CHALL, W. COASTAL HOSPIE P.O. Bix 1733 Scalisbury MD 21802  State 31. Date filled (Month, Day, Year) 32. Pegistrar's Signature	)	To t	M	29b. Signature and title of certifier	/10 V	. ^			1	-		
Transfer of the second of the	H	.5	ato	PAVID COLALL, 1	IN COASTALA	m 23a) (Type, Print)  HOSPILE  Auture	10. Bx 1	233	Salist	pur /	MO.	21802

		·	For State Registrar	State of Maryland		artment of H		R	eg. No.	15   464
ı	Physicia		1. Decedent's Name (First, Middle, Last RICHARD)	BEVAN	/			2. Date of Deat		Year // 15 0 M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or SALL	Location of De	y	4c. County of	Death COMICO
i	Funeral Director		139-10-1011	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		Year) 926	9. Birthplace (State or Foreign Country) Ohio
	yland how		Usual Residence of Decedent  10a. State 10b. County	10c. City	Town or Lo	ocation				10d. Inside City Limits
	death with the Maryland ms 23a or 28e-f show r must be notified at	Director	MD Wicomico	S	alisb	ury 10f. Zip Code			0- 00:	1 XYes 2 No
	3a or		608 Sherwood Cir	cle		21804			0g. Citizen of Wh	•
036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heatilt and Mental Hygiene it fleatilt and Mental Hygiene it flem 27 is marked a theritan "natural", or items 23a or 28e-f show other treatural is a marked other transmitter maint be notified at other treaturatic event, the Modical Examiner maint be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: ₩₩II		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race	- American Indian, , White, etc. White
21215-0036	within 72 hours after ene. than "natural", or Ite re Wedical Examina	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	ation furing most of w	vorking	16b. Kind of Busi	
22	Hygien Hygien ther th		12 17. Father's Name (First, Middle, Last)	5+	De	ntist	18 Mother's N	lame (First, Middle, I	Dent	
<u>au</u>	ould be filed withir I Mental Hygiene. Narked other than Natic event, Ite Ma	То Ве	David Arnold Bev	an				et L. McB		,
Maryland	t and 2 should Health and Men tem 27 Is marke other treumatic		19a. Informant's Name/Relationship (T) Martha L. Bevan/W	,				Rural Route Number , Salisbui		
altimore,	Pages 1 and 3 nent of Health int: If item 27 iry or other tre		20a. Method of Disposition 1  Burial 2  Cremation 3  4  Donation 5  Other (Specify,	Removal from State 20b. Pl	ace of Dispo metery, crei	sition (Name of natory or other plac	θ)	Date	20c. Location - C	ity or Town, State
Saltir	permit. Pages Department of Important: If it any injury or conce.	1	21 Signature of Funeral Sevier Cons		22	2. Name and Address.nman Fune	s of Facility	-	alisbuly	, Haryland
m M	205 # 9		And All Street the disease or comp	M00295	111	673 Some	set Ave	Prince	ss Anne	MD 21853 Approximate
	Physician	0	2a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.	Obstr	Ane 1	um	Dicense		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):		0	.07)		- Cyra
	bed isi	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a consequ	ence of):					
8760,	ficate be executed physician and is the burial-transit	dical Examiner	that initiated events resulting in death) Last	c	ence of);					
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0_	w requires that the bound by should be detained by	by	Part II. Other significant conditions co	ntributing to death but not resu	Iting in the u	nderlying cause give	en in Part I.			oute to the cause of death?
Records,		Completed						24a. Was a autops perform	y pri ned? de	ere autopsy findings available or to completion of cause of ath?
Vital	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	denitely d				eath (Check only on		
o	ding Physician: The In. After this certificate hatfuneral director, page	1: To	1 Yes No 27. Manner of Death	28a. Date of Injury	P/Outpatier 28b. Time o		4 🗆 Nursing	Home 5 Reside		
ion	ttending F death. ctor: After y the funer	atlor	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work	k? Yes 2 □No		,	
Division of	after Dire	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, sti	reet, factory, office	-	28f. Location (St City or Town		or Rural Route Number,
	e Hospital	edical (	29a. Certifier (Check only one)  2 Medical Exam	sician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, deat ion and/or in	h occurred at the tim vestigation, in my of	e, date and pla pinion, death oc	ce, and due to the cacurred at the time, do	use(s) and manrate and place, an	ner as stated.  Indicate to the cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	100 1	ear	29c. License	number	F 2	,	(Month, Day, Year)
			30. Name and address of person who c		23a) (Type,	Print) R. 13	22 (	Salubin	VA N	21802
	Sta		31. Date filed (Month, Day, Year)	CONSTAL HISPICE 32. Registrar's Signat	ure	. Box 17		CINDIA	NID	0.100-

			For State Registrar	State of Marylar		artment of F rtificate of			giene Reg. No.?) () () ()	
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	John L. Bent	on			2. Date of Dea		3 Time of Death C
I	Examin		4a. Facility Name (If not institution, give st				r Location of Deat		4c. County of De	ath
	Funeral Director		Anne Arundel Med: 5. Social Security Number 6. Sex 150 150 150 150 150 150 150 150 150 150	7. Age (In yrs.	last birthday) Yrs.	Anna If Under 1 Year Months Days	polis If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day Sept. 1	Anne ar 7, Year) 9. 8 18,1923 W	undel inthplace (State or Foreign Sountry) ash. DC
	ryland how		Usual Residence of Decedent  10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits
	the Ma	Director	Md. Prince Geo	orges		Bow:	ie		100 Citizen of Mines	1 ŽYes 2 □ No
	h with	al Dir	12836 Holiday Lane	2		· ·	20716		10g. Citizen of What ( USA	Sountry ?
036	n 72 hours after death with the Maryland "neturel", or Items 23a or 28a-1 show salical Exprojuetrans be neithed at	by Funeral		2. Was Decedent Ever in U Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII	1	Was Decedent of H I Yes, specify Cuba I Yes 2 No		pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh	nerican Indian, hite, etc. hite
21215-0036	within 72 sne. than "ne:	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) Coilege (1-4or 5+)	(Give   life. L	dent's Usual Occup kind of work done DO NOT use retired mber	during most of wo	rking	16b. Kind of Busines	s/Industry
Maryland 2	ould be filed wi Mental Hygien arked other th atic event, the	Be	17. Father's Name (First, Middle, Last)	jamin F. Bent	- on			ne <i>(First, Middle,</i> ohia Ber	Maiden Surname)	
ary	S P E E	T <sub>0</sub>	19a. Informant's Name/Relationship (Typ	·		g Address (Street			r, City or Town, State	, Zip Code)
	s 1 and 2 of Health a item 27 is other tree		Nora C. Benton - V						ryland 207	
altimore,	8 - = 0		20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	illoval itotti State		sition (Name of natory or other place of the control of the contro	1		20c. Location - City of	e, Maryland
Baltii	perriit. Page Dep riment of Important: if any injury or once.		21. Signature of Funeral Service Licenses		22	. Name and Addre	ss of Facility B	eall Fun	eral Home ie, Maryla	NEW EXERCISES
	Physician /Medical		23a. Part1. Enter he disease, or complic shock, or heart lailure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the deat e cause on each line.	th. Do not ente					Approximate Interval Between Onset and Death
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	ysician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner?  1  Yes /2 No	ospital:	ER/Outpatien	t 3 DOA Oth		th (Check only on	ne) ence 6 □Other (Sp	acital TI
on of	iding Phy th. : After this funeral o	tlon: T	27. Manny of Death 1 Latural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work			ow injury occurred	өспу)
Division	Hospitel or Attending Physician: 24 hours after death. Funerel Director: After this certific tely filled in by the funeral director.	Certification:	3   Suicide 6   Could not be determined	28e. Place of Injury - At h building, etc. (Specil	ome, farm, stre (y)			28l. Location (St City or Town	treet and Number or F n. State)	Rural Route Number,
	e Hospitel or 24 hours afte e Funerel Dir letely filled in	edical (	29a. Certifier 1 Certifying Physi (Check only one)	cian: To the best of my kno er: On the basis of examina	owledge, death	occurred at the tin	ne, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and manner a ate and place, and du	is stated.
	To the within 2 To the complet	Med	29b. Signat e. nd title of certifier	and manner stated.		29c. Licenso	a number	2	9d. Date signed (Mgr	oth, Day, Year)
L	(2) W		30. Name and address of person who con			Print)			(//-/-	, ,
1	Sta		Hung Davis MD, 31. Date filed (Month, Day, Year) APR 1 8 2005	2001 Medica	1 Parky	vay, Anna	polis, M	aryland		

			101	partment of Health and Mertificate of Death	, 0.	2005	11,61,3
	•,		Decedent's Name (First, Middle, Last)	Tancate of Death	Reg. 2. Date of Death		3. Time of Death
	Physici /Medi		KATTORIA A. BUTLER		APRIL 12	Day Year 2 2005	10:15 P M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	th
A.			1007 DUMFRIES STREET	OXON HILL  If Under 1 Year   If Under 24 Hrs.		PRINCE G	
	Funeral Director		5. Social Security Number  578-82-4094  Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 3-14-62	(ar) [ $Cc$	thplace (State or Foreign buntry) SH., DC
	land ow		10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	Many a-fah	tor	MD PRINCE GEORGE OXON HI	LL			1 <b>XX</b> Yes 2 ☐ No
	or 28,	Olrec	10e. Street and Number	10f. Zip Code		Citizen of What Co	ountry?
	s 23c	rai	1007 DUMFRIES STREET	20745		J. S. A.	
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Itam 27 is marked othar than "natural", or Itams 23s or 28a-1 ahow or other traumatic avent, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married  1 Never Married  2 Married  3 Was Decedent Ever in U.S. Armed Forces?  1 Never Married  12 Was Decedent Ever in U.S. Armed Forces?  1 Never Married  14 Was Decedent Ever in U.S. Armed Forces?  15 Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 Yes X No Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
5-0	72 h	etec	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of workir DO NOT use retired)	ng 16b	. Kind of Business/	
121	within ene. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  12TH GRADE	CASHIER		D. C. GOV	
	filed Hygi othar ent,	a)	17. Father's Name (First, Middle, Last)	18. Mother's Name			
Maryland	d 2 should be filed within 7 th and Mental Hygiene. 7 is marked othar than "r traumatic avent, the Med	To B	JAMES HARRINGTON	MARVA	WADDY		
Ma	id 2 st Ith and 27 is n traun			ling Address (Street and Number or Rural  DUMFRIES ST. OXON			Zip Code)
ē,	permit. Pages 1 and 3 Department of Health Important: If Itam 27 any injury or other tru once.		20a. Method of Disposition 20b. Place of Disp	osition (Name of D		Location - City or	Town, State
E	Pages nent of int: If It		Andural 2 Cremation 3 Anemoval from State	ematory or other place) ILL CEMETERY 4-18-	-05 SU	ITLAND, M	ID.
Baltimore,	permit. Page Department Important: If any injury or once.			22. Name and Address of Facility PINC	-		
-	Dep any			524 - 8TH ST., N. E		, DC 2000	2
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. LUNG CANCER  Due to (or as a consequence of):	iter the mode of dying, such as cardiac or	r respiratory arrest,		Approximate Interval Between Onset and Death YEARS
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):				
O. Box 6	death certifi e attending d for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
٦,	requires that the een signed by th nould be detache	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ord	w require been sig should b	ted t			1 ☐ Yes	2 □ No 3 <b>XX</b> ro	obably 4 Unknown
Records,	3 0 0	Completed			24a. Was an autopsy	prior to c	topsy findings available completion of cause of
_	: The	Con			performed' 1 ☐ Yes XX	? death?	2 No
Vital	Physiclan: The la this certificate had ral director, page 2	Be c	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death			
of	<u>a</u> = <u>a</u>	To To	27. Manner of Death 28a. Date of Injury 28b. Time (	THE SELECT 4 INDISING HOLD	e 5 <b>X</b> Residence 8d. Describe how in		rify)
ion	Attending I r death. sctor: After by the funer	atloi	1 X Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 □ Yes 2 □ No			
Division	Dirte o	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	8f. Location (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
	ne Hospital n 24 hours a na Funaral b bletely filled	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, an ivestigation, in my opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and little of certifier	29c. License number	29d. [	Date signed (Month	, Day, Year)
			Dalay D. Mangan	D32800	Al	PRIL 14,	2005
R	(15)		30. Name and address of person who completed cause of death (Item 23a) (Type HILARY H. WASHINGTON, M.D. 11701 LIV	Print) INGSTON RD. #205 F	T. WASHI	NGTON, MD	20744
	Sta		31. Date filed (Month, Day, Year)  A PR 1 5 2005	K)			

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year 11:40 AM W. Bennett, Jr. April 10 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Catonsville Baltimore Forest Haven Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 XM 2 □ F 214-05-1246 87 Yrs. 27, 1918 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Glen Burnie 1 ☐ Yes 2 No Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7975 Crain Highway South, #322 U.S.A. 21061 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1941-43 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Banking and Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nathalia Lauer John William Bennett, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7975 Crain Hwy. South, #322 Glen Burnie, MD 21061 Lillian Bennett/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, Maryland Glen Haven Mem. Park | 4/14/2005 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home Funeral Service Licensee 21. Signature 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEROTIC disease or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that introduced to the control of Due to for as a consequence of: that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 (2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 6 Other (Specify)

Physician /Medical Examiner

permit, Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar trat <u>once.</u>

**Physician** 

/Medical

**Examiner** 

Director

Completed by Funeral

Be

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**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. and to Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or Itams 23a or 28a-f show

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

in marked outside the natural, or itams 23a or 28a-f show traumatic evant, if a Modical Examiner must be notified at

attending physician and for use as the burial-transit

Examine ian/Medical Physici by Completed Be 2 Certification:

27. Manper of Death

Natural

29a Certifier (Check only one)

2 Accident 3 Suicide

4 Homicide

29b. Signature and title of certifier

The law requires that the death certificate be executed the by Physician: this After To the Hospital or Attending after death. in sy

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASNEE LAKHANI

5 Pending investigation

6 Could not be

determined

29c. License number 1595

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as sizes.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year)

7220

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

strar's Signature 31. Date filed (Monti

within 24 hours a To the Funeral I

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 24a par mr 8842 4-29-05 yt and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Rosalie G. Barnhart April 2005 - /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Coffman Nursing Home Washington Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea **Funeral** 1 □ M 2 🛱 F Yrs. Director 219-12-0465 August 7. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1304 Pennsylvania Avenue 21740 **USA** Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 XNever Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced White traumatic evant, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Examiner Clothing Manufacture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ould be f Mental H 2 William H. Barnhart Sadie Graham Jet, N. Jermit. Pages 1 and 2 st.
Department of Health and 2 mportant: If item 27 any Injury or 7 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy J. Mosier/Daughter 142 West High Street Hancock, MD 21750 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Thomas 'Episcopal \* 4 ☐ Donation 5 ☐ Other (Specify) 04/22/05 Hancock, MD 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): 68760 death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months2 4☐ Pregnant at time of death 9☐ Unknown Month Day Year 5 Other (specify) 1 Yes 2 TH 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Denknown 24b. Were autopsy findings available prior to completion of cause of death? perform 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to redical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attanding 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dirac 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signarure and title 29c. License number cause of death (Item 23a) (Type, Print)

Registrar

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			1 - For Registrar	State of Marylan		irtment of H			giene () (	)5	14647
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•	/Medio Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of D		4c. County		8:45p <sup>™</sup>
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	Funeral		5. Social Security Number 6. Sec		last birthday)	Cheste It Under 1 Year	If Under 24		Kent	9. Birthpla	ace (State or Foreign
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	ים		Usual Residence of Decedent					1101 2	3 1711	Hai	yranu
	ylan how		10a. State 10b. County	10c. City	, Town or Lo	cation				10	d. Inside City Limits
	Ma 1-8	Ş	MD Kent	St	:111 H	Pond					1 Yes 2 No
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Count	ry?
	h wii		12700 Still Po	nd Rd.		21620	)		U.S.A.		
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Maryland 21215-0036	2 sh and sand eum	. 1	19a. Informant's Name/Relationship (Ty					r Rural Route Numbe	er, City or Town, S	State, Zip (	Code)
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show amportant: If item 27 is marked other than "natural", or items 23a or 28e-f show appring to other treumatic event, the Medical Examiner must be notified at once.	n i	21. Signature of Funeral Service Livens	20	C22	Name and Address	s of Facility	Home of	F Stanh	on T	. Schaec
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	\		30. Name and address of person who co	moleted cause at death //to-	23a\ /Tune	Print)	700			-/	
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	/Medic		Carolyn Regina  4a. Facility Name (If not institution,		mber)		4b. City, To	own, or Lo	ocation of D	)eath		4c. Cou	inty of Death		
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatin and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or Items 23a or 28e-f show any injury or other treumatic svent, the Medical Evantiant must be rediffied at once.		21. Signature of Funeral Service I	icensee									ral Ho	-	
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CAROLYN Division of	or At or or At or At or At or At or At or At or At or At or At or At or	Certification;	4 Homicide determine	ned 208. Flat	ding, etc. (Specify)	ne, rami, si	riest, ladory,	OHICE			ity or Town				2011
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5	q		30. Name and address of person									0.0			
				.D. 37	767 MARKE	T DR	LVE C	HARL(	TTE I	HALL,M	<u>ש.206</u>	22			
	Sta Regist	ate trar	31. Date filod (Month, Day Year)	1 9 2005	Magne .	K	Crail	40							
					4 44 44										

		,	1 - For State Registrar		of Maryland		artmen rtificate					Reg. No.	. UU	5		649
П	Physici	an	1. Decedent's Name (First, Middle		1 M1 - F 10						2. Date of Dea Month	ath Day	, Y	ear ear		of Death
	/Medic				CARTER						4	20		05	10:	20 AM
	Examin	er-	4a. Facility Name (If not institution	-					Location o			4c.	County of	. 1		
			UNIVERSITY OF M  5. Social Security Number	6. Sex	7. Age (In yrs. las		If Under		If Under:		0.0			/A		
	Funeral Director		214-28-4800	1. ŽŠM 2. F		Yrs.		Days	Hours	Min.	8. Date of Birt (Month, Da	y, Year)	9	Countr	y)	e or Foreign
			Usual Residence of Decedent								July 16,	1924	r	Maryla	and	
	yland		10a. State 10b. County		10c. City, 1	Town or Lo	cation	-						10	d. Inside	City Limits
	Mar-	tor	Maryland Saint	Mary's	A	venue									1 🗆 Y	es 2∑No
	or 28	ire	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of Wha	at Countr	y?	
	23a	Funeral Director	38895 Hodges Road				200	609					USA			
	r dea	ne	11. Marital Status	12. Was Dec	edent Ever in U.S. prces?	13. \	Was Deced f Yes, spec	ent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	-	14. Race -	America White, et		
36	or it	by Ft	1 Never Married 2 Marr	If Yes, Gir	ve	1	1 ☐ Yes 2				,		Specify:			
Ö	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or items 23s or 28s-1 show ant, the Medical Examinar must be motified at	d b	3 Nidowed 4 Divorced	Year or D		10. 0	1									
7	n 72 "nai	Completed	15. Deceden (Specify only highes	st grade completed)		(Give	dent's Usua kind of wor DO NOT us	k done d e retired	ition <i>uring m</i> ost	t of worki	ng	16b. Ki	nd of Busir	ness/Indu	istry	
72	withi ene. than	JII.	Elementary/Secondary (0-12) 7	College (	1-4or 5+)	Farm		0 /01//00/				Tob	acco Fa	0 2°m		
D	Hygother ent,	BeC	17. Father's Name (First, Middle,	Last)		Tarm	<u> </u>		18. Mothe	r's Name	(First, Middle.			a1 III		
au	lenta lenta ked ic ev	To B	James Carter						Bert	ha Yo	rkshire					
Maryland 21215-0036	shou and N s mai		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address	(Street a			l Route Numbe	er, City o	r Town, Sta	ite, Zip C	ode)	
	and 2 naith a n 27 th		Mildred Theodora Ma	ason / Siste	r	46217	Scott	Circ	le, Le	x <b>i</b> ngt	on Park,	Mary	land 20	0653		
ore	of He of He fitem roth		20a. Method of Disposition	2 Domount from	com	e of Dispo	sition (Nam	e of her place	a) 1	Apr	ate	20c. Lo	cation - Cit	y or Tow	n, State	
<u>Ĕ</u>	Pag ment ant: i		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			d Hear	t Ceme	tery	1	27.		Bush	wood, l	Maryla	and	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Modical Examinat must be notified at an once.		21. Signature of Funeral Service	nsee		22	Name and	Addres	s of Facility	V	ral Home,					
_	g Q E # 9		Myle	comour		P.0	O. Box	270,	Leona	rdtow	n, Maryla	and 20				
			23a. Part . Enter the disease, or shock, or heart failure. List	complications that conty one cause on e	aused the death. I each line.	Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory ar	rest,		11	oproxim	etween
	Physician		Immediate Cause (Final disease or condition	_ a. `IS	CHEMIC	HE	EART	D	ISEA	SE				3	nset an	d Death
	/Medical Examiner		resulting in death)	Due to	(or as a consequen	nce of):										
		<u>_</u>	Sequentially list conditions	b IS	CHEMIC (or as a consequen	COL	エフエ	. S						/	14	Days
	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>.</b>												
	al-tra	Examiner	that initiated events resulting in death) Last		OLO RE T		CAN	CE						+	5)	perus
8760,	icate be executed physician and s the burial-transit	dicai E		d										Ī		
9	ifficat g phy as the	edic											17)			
Вох	leath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy birth 2 Petal de		N=-4:					2	3d. Date of	f delivery		
	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of death		Ectopic pre Other (spe						Month	D	ay	Year
P.O.	that the de led by the a detached t	hys	9 ☐ Unknown													
	es be	by	Part II. Other significant condition	ns contributing to de	eath but not resultin	ng in the un	nderlying ca	use give	n in Part I.		23e. Did to		_			
Records,	w requir been si should	Completed							<del></del>		1 U Y	'es 2[	]No 3[	] Probab	ly 4 💆	Unknown
ec	has b	npie									24a. Was a	sy	24b. Wer	e autops	y finding pletion of	s available cause of
<u></u>		Con									perfor 1 ☐ Yes	med? 2 <b>⊠</b> No	deat	h? * Yes 2		
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				-			(Check only or					
ot	Phys this ral dir	L.	1 Yes 2 No 27. Manner of Death	28a. Date		Outpatient		- 11	4 🗆 1401		ne 5 Resid			Specify)		
Division of	ding h. After funei	tion	1 Natural 5 Pendin. 2 Accident investig	g (Mont	th, Day Year)	Injury	M	lc. Injury Work'	ai ? es 2⊟N	- 1	8d. Describe h	ow injury	occurred			
18	Attendi death. ctor: A y the fu	fica	3 ☐ Suicide 6 ☐ Could r	not be	of Injury - At home	, farm, stre			201		8f. Location (S	treet and	f Number o	r Rural F	Route Nu	mher
á	at or A safter i Direction by	Certification;	4 Homicide	buildi	of Injury - At home ng, etc. <i>(Specify)</i>		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				City or Tow	n, State)				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.		29a. Certifier (Check only)  Certifyin  Medical	g Physician: To the	best of my knowle	dge, death	occurred a	t the time	, date and	place, a	nd due to the c	ause(s)	and manne	r as state	ed.	
	in 24 in 24 the Fi	Medical	one)	Examiner: On the ba and mann	asis of examination ner stated.	and/or inv	estigation,	in my opi	nion, death	h occurre	d at the time, d	date and	place, and	due to th	e cause	(s)
	To	Σ	29b. Signature and title of certifier				1	License				- 4	signed (M			
,			1 print	who MD			AU	4176	4357	T1580	53	4	PRIL	. 20	) <sup>th</sup> ,	2005
			30. Name and address of person							maco -	4.4					
	Cha	100	BRIAN T 31. Date filed (Month, Day, Year)		AL Sour	th Gre	ene Si	treet	Brut	timo	e Mary	land	\			
	Sta Registr		APR 2	5 2005	oistrar's Signature	A	no de	8								

	1	State Registrar  1. Decedent's Name (First, Middle, Las	State of Ma	aryland / Depa		Health and	Mental Hy	giene Reg. No.	202-	1465
Physiciar /Medica Examine		4a. Facility Name (If not institution, give	street and number)			, or Location of Deat		Day 18	2005 County of Dea	ath
Funeral Director		Usual Residence of Decedent	X 4 c S 7 7 Age	(In yrs. last birthday)	If Under 1 Year Months Day		8. Date of Bir (Month, Da	th ay, Year) -28	9. Bi	nthplace (State or Forei ountry)  Jerse
Ba-f show			ington	10c. City, Town or Lo						10d. Inside City Limi
23a or 2	a D	10e.Street and Number  9 South Shirley A	Ave.		10f. Zip Code	8057		10g. Citiz	zen of What C	ountry?
al", or itema 23a or 28a-f si Examiner must be notified	חא רשוופו	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	10	Was Decedent o If Yes, specify Cu	f Hispanic Origin? (Suban, Mexican, Puer lo <i>Specify:</i>	Specify Yes or No to Rican, etc.)	1	4. Race - Am Black, Whi Specify: W	ite, etc.
Department of Health and Mental Hygiends in Items 23s or 28s-1 show important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show injury or other traumatic event, the Medical Examinar must be rediffied at once.  To Be Commisted by Eurored Director	ombiered	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 1 2	ucation de completed) College (1-4or 5	(Give	dent's Usual Occ kind of work dor DO NOT use reti efuse Ha	ne during most of wo red)	rking	16b. Kir	nd of Business	Removal
narked otheratic event,	ם מער	17. Father's Name (First, Middle, Last) John Clyde				Lill:	me (First, Middle ian Forc	e		
Health and em 27 is mu ther trauma		19a. Informant's Name/Relationship (7 Marilyn J. Clyde/	,			et and Number or Ru Lrley Ave.				
Department of He Important: If Iten any injury or oth once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  1 ☑ Donation 5 ☐ Other (Specify	)	Calvary	matory or other p Cemetery	Apri	Date .127,200.	5 Ch		ill, NJ
Important in suny in suny in sunce.		21. Signature of Funeral Service Licens	500	F F	2. Name and Add ellows, 30 Speer	ress of Facility Helfenbei Road, Ch	n & Newn	nam F wn. M	uneral D 2162	Home P.A.
ysician Medical taminer		23a. P. 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	the death. Do not ent	er the mode of d	ying, such as cardia Newwo W	c or respiratory a	rrest,		Approximate Interval Between Onset and Death 2 days
sian and urial-transit	LVa	Sacuar halfy list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. F/1A	a consequence of):  A (JUT) a consequence of):	190 0he	· ma				years years
ed by the attending physic detached for use as the by Dhysic and Medician Medical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnar Other (specify)			2	3d. Date of de Month	ilivery Day Year
be o	2	Part II. Other significant conditions co	entributing to death but	ut not resulting in the u	nderlying cause	given in Part I.		obacco us Yes 2		o the cause of death? robably 4 □Unknov
ate has	on high						24a. Was auto perfo 1 - Yes	psy prmed?	24b. Were a prior to death?	utopsy findings availab completion of cause of
his certificate	2	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 X Inpatie	nt 2 ☐ ER/Outpatier	nt 3 DOA	\thor.	ath (Check only of		□Other /Sne	aciti.
After t funera		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injur (Month, Day	y 28b. Time o ( Year) Injury	M 28c. in	ury at lork? Yes 2 No	28d. Describe	how injury	occurred	
within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined	building, etc				City or To	wn, State) 		ural Route Number,
thin 24 hours the Fune smpletely file	No.	(Check only one)  29b. Signature and fille of certifier	iner: On the basis of and manner sta	of my knowledge, deat examination and/or in ited.	vestigation, in my	opinion, death occu	e, and due to the urred at the time,	date and	place, and due	e to the cause(s)
3 - 3		1 hillion	Stre	amer	D	26789	1		18.0	0 57
		30. Name and address of person who of William Di	Traingr	e 1223	Print) Deep2	12d ,C	hester	tow	n me	06916
State Registra		31. Date filed (Month, Day, Year)	2005 32. R distra	ar's Signature	Acres 1					

			Please	Type or Print in					_	÷.
			For State Registrar	State of Maryla		epartment of I Certificate of			iene g. N2 0 0 t	14651
	Physici		1. Decedent's Name (First, Middle, La	nn Crum				2. Date of Death Month	Day Ye	
	/Medic Examin	-	4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town,	or Location of Death	115:11	4c. County of D	
			North Arond	el Hospita	/	Glen	Bornie		Anne	Arundel
	Funeral Director			Sex 7. Age (In yr 1 ☐ M 2 ☐ F		nday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Sept. 7,	rear)	Birthplace (State or Foreign Country)
þ			Usual Residence of Decedent	24			<u> </u>	ерг. 7,	1939 F	ennsylvania
200	shoy	٦	10a. State 10b. County		-	or Location				10d. Inside City Limits
ē.	28e-f	ectc	Maryland Freder	LCK En	mits					1 ☐ Yes 2 ☐ No
ING ZIZI3-0030 be filed within 72 bours after death with the Maryland	3a or 3	Funeral Director	10588 Taneytown 1	Pike		10f. Zip Code 217	27	10	g. Citizen of What U . S . A	-
death	TIS 2	nera	11. Marital Status	12. Was Decedent Ever in	U.S.	13. Was Decedent of I	Hispanic Origin? (Spe	cify Yes or No-	14. Race - A	merican Indian,
after o	or Ita		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 No		tican, etc.)		hite, etc.
	Exa	d by	3 Widowed 4 Divorced	Year or Dates:					Specify:	White
<u>ה</u>	"nat	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working	g 1	6b. Kind of Busine	ess/Industry
A id	then then	шо	Elementary/Secondary (0-12)	College (1-4or 5+)		Seamstres	•		Sewing	Factory
d be filed	otha otha ent,	Be C	17. Father's Name (First, Middle, Las	1)			18. Mother's Name	(First, Middle, M		ractory
arylar should b	Menta Irked Itic e	ToE	Maurice Eckenrode	2			Oneida Se	1by		
	a - a		19a. Informant's Name/Relationship Richard L. Crum			Mailing Address (Street 588 Taneyto				
<b>6</b> 5	Heal tem 2 other	- à	20a. Method of Disposition	206		Disposition (Name of crematory or other pla			Oc. Location - City	
Pages	ent of nt: If i ry or		1 XBurial 2 ☐ Cremation 3 [ '4 ☐ Donation 5 ☐ Other (Spec			r, crematory or other pla Evan. Luth.				, Maryland
Dallimor	C 42 ->		21. Signaturu Truj dal Selvic de	have A		OBERT E		1		
Ď	Depa Impo any is		Schetch	till best		615 EAST M	AIN ST T	ON FUNEI HIIRMONT.	KAL HOMES MD 2178	, P.A.
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nblications that caused the de one cause on each line.	ath. Do n	ot enter the mode of dyi	ng, such as cardiac or	respiratory arre	st,	Approximate Interval Between
	hysician Medical		Immediate Cause (Final disease or condition resulting in death)	a Cexebrava	اء حداد	r accident	t			Onset and Death
	Medical xaminer		f	Due to (or as a cons	equence o	0:	bland			Luxal
		e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cons	edneuce o	ganglia	Dieta			1 0038
cuted	nd transit	amlne	cause. Enter Underlying Cause (Disease or injury that initiated events	2						
exe	o <u>.a</u>	EX	resulting in death) Last	Due to (or as a conse	equence o	f):				
o de be	nysicia he bu	cal		d						
artificat	attending physician ar for use as the burial-t	Physician/Medical	IF FEMALE:							
DOX	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg	tal death	3 Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
; è	ed by the attendir detached for use	yslc	1 □ Yes 2 ເNo 9 □ Unknown	4□Pregnant at time of 9□Unknown	death	5 Other (specify)				
F at	ed by		Part II. Other significant conditions	contributing to death but not re	esulting in	the underlying cause giv	ven in Part I.	23e. Did toba	acco use contribute	to the cause of death?
w requires	s been signed to	d by	Remal tailute	- on dialysi	\$			1 🗆 Yes	3 □	Probably 4 Unknown
5 §	s beel	olete	Perisheral was	sculor dise	12			24a. Was an	24b. Were	autopsy findings available
The law requires that the death certificate be	certilicate has t irector, page 2 s	Completed	Congoctive h	east Carlune		sulin dopun	dant diabeter	autopsy perform	ed? prior death	o completion of cause of
		Be C	25. Was case referred to medical	Zur ( () ()	1 1 1	201101 (0)	26. Place of Death			65 2 140
Physicien:	this certific	70	examiner? 1 Tyes 2 No	Hospital: 1 Inpatient 2	☐ ER/Out	oatient 3 DOA			ice 6 Other (S	pecify)
odina P	h. After th funeral	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Ti	jury Wo		3d. Describe how	v injury occurred	
tend C	or:	icat	2 Accident investigation 3 Suicide 6 Could not to		hama (		Yes 2 □No	N. 11 (Ot		
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	after death Director: In by the	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, tan	n, street, factory, office	28	City or Town,		Rural Route Number,
the Hospitel or Attending	within 24 hours after d <b>To the Funerel Direct</b> completely filled in by		29a. Certifier Certifying P	hysician: To the best of my k	nowledge.	death occurred at the til	me, date and place, ar	nd due to the cau	ise(s) and manner	as stated.
oH ec	n 24 l he Fu oletely	edical	(Check only 2 Medical Exa	hysician: To the best of my ki miner: On the basis of examinand manner stated.	nation and	or investigation, in my o	ppinion, death occurred	d at the time, dat	e and place, and d	ue to the cause(s)
Tot	To ti	Me	29b. Signature and tive of certifier	1	10	29c. Licens	se number	290	d. Date signed (Mo	nth, Day, Year)

State Registrar 30. Name and address of person whompleted cause of death (Item 23a) (Type, Frint)

STUART Jacchs mo 305 (Jospital Dr. Glen Burnie, Mp 21061

31. Date filed (Month, Day, Year)

APR 18 2005

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Day **Physician** 200°5 13, Ester Louise Crandall 5:55 p<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 6290 Chicamuxen Road Charles Indian Head If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 T F Director 215-38-7334 64 Yrs. 18,1940 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other then "netural", or Items 23e or 28e-f ehow treumetic event, the Madical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6290 Chicamuxen Road 20640 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "netural", or Items 23e any Injury or other treumetic event, the Medical Examiner must, once. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: Winite 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Her Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Elven Craven Maxine Runion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry R. Crandall 6290 Chicamuxen Rd., Indian Head, Md. 20640 Husband 20b. Place of Disposition (Name of cametery, crematory or other place) April 18, 2005 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State Chicamuxen United Methodist \* 4 ☐ Donation 5 ☐ Other (Specify) Chicamuxen, Maryland 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20640 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Concu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the aid be detached for 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown been si should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? this certificate 2 No 1 Yes 1 ☐ Yes 2 ☐ No il or Attending Physicien: after death. Director: After this certifica 25. Was case referred to medical Be 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Pasidence 6 Other (Specify) 1 Tyes 21 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Da crit e how injury occurred Certification: -1. □ Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident illed in by the 6 Could not be determined Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 07 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 15 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 **Physician** Month 9, 3:10 P M April Edward Irvin Carter, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore 8622 Allenswood Rd. Randallstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 04/02/1940 Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F 65 Director Maryland 219-26-3014 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show or other traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States "netural", or itema 23e 8622 Allenswood Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: Korea 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Š 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry othar than Elementary/Secondary (0-12) College (1-4or 5+) 12th Fabricator ED-K Machine 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Intportant: If item 27 is marked oth any injury or other traumatic evani Be 18. Mother's Name (First, Middle, Maiden Sumame) Francis Edward Carter Evelyn Virginia Kuntz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Carter (Wife) 8622 Allenswood Rd. Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Lake View Mem Park 4 Donation 5 Other (Specify) 4/13/2005 Sykesville, MD 21. Signatur of Funeral Service License 22. Name and Address of Facility
Burrier-Queen Funeral Home and Crematory, P.A. 1212 W. Old Liberty Rd. Winfield, MD 21784 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate In rval Between On let and Death fmm dicte Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) ☐Yes 2☐No be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? /es 2 No certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturaí 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check or one) land manner stated. 29d. Date signed (Month, Day, Year) 10\* (Item 23a) (Type, Print) 6 31. Date filed (Month, Day, Year) APR 1 2 32. Registrar's Signature State 2005 Registrar

			101	artment of Health and Menta		(D) (B) (c)	
			Decedent's Name (First, Middle, Last)		Reg. te of Death	4000	3. Time of Death
	Physici		William Thomas Covington, Jr.		inth	Day Year 2005	1:45 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
ı	X		Carroll Hospital Center	Westminster	1	Carroll	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Dat	te of Birth onth, Day, Ye	9. Birthi	place (State or Foreign
	Director		402-40-1096   <sup>1⊠M 2□F</sup>   68 Yrs.	Months Days Hours Min. (Mo	il 9,	1937 Kent	
	pu 🌬	1	Usual Residence of Decedent         10c. City, Town or Lo.           10a. State         10b. County         10c. City, Town or Lo.	nestion .			10d. Inside City Limits
	shor	5		Adjoir			1 ☐ Yes 2 ☑ No
	the N 28a-f	Directo	Maryland   Carroll   Woodbine	10f. Zip Code	10-	Cirina of Maria	
	a or		6010 A Woodbine Rd.	21797		Citizen of What Cou ited State	•
	eath	Funeral		Was Decedent of Hispanic Origin? (Specify Ye		14. Race - Ameri	
<b>,</b>	r Iten	핊	Armed Forces? 1955-	If Yes, specify Cuban, Mexican, Puerto Rican,	etc.)	Black, White,	etc.
93	al', o	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1964	1 ☐ Yes 2 ☑ No Specify:		Specify: V	White
9	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ant, the Madical Examiner must be notified at	Completed		dent's Usual Occupation kind of work done during most of working	166	. Kind of Business/In	dustry
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p	be fil tal H d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First,		den Sumame)	
Z	ould Men Parke	ို	William Thomas Covington, Sr.	Ruby Gibbs			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itsm 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at ODGe.			ng Address (Street and Number or Rural Route		ity or Town, State, Zip	Code)
e,	1 and Healt sm 2 thar			ox 163 Woodbine, MD 21		. Location - City or To	own State
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Baltimore,	iit. Partme ortani injury			Ridge Cem. 4/14/2005	-	dbine, Man	
Ba	Depi Impo		The little 12	2 Name and Address of Facility Irrier-Oueen Funeral H 212 W. Old Liberty Rd.	Home and Winf:	nd Cremato ield, MD 2	P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or respir	ratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a. Pneumotty	Lax			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
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	ed isit	ine	ause. Enter Underlying Cause (Disease or injury Cause (Disease (Dise				
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687	ficate   physical	edicai	d				
XO	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	erv
$\mathbf{m}$	death a atte d for	cia	in the past 12 months?  1 Ves 2 No.  4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year
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Vital	Physician: Th r this certificate ral director, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (Chec.	k only one)		
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Division of	l or Attanc after death Diractor: I in by the	Certification:	28e. Place of Injury - At home, farm, structure determined building, etc. (Specify)	eet, factory, office 281. Loc City	y or Town, S	t and Number or Rura tate)	al Route Number,
	pital ours a aral (		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deat	h conversed at the time, date and place, and dur	to the seven	2(2) 224 222 22 22	and a
	To the Hospital or Attanding within 24 hours after death.  To the Funaral Diractor: After completely filled in by the fune	Medical	(Check only one)  Otherwise (Check only one)  Otherwise (Check only one)  Otherwise (Check only one)	vestigation, in my opinion, death occurred at th	e time, date	and place, and due to	the cause(s)
	To th within To th sompl	Me	29b. Signature and tille of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
	WIL		HILCOMELEN MID	D-0054218	0	4-11-0	5
	My		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	1	, , , , ,	54.00
			DR Raman B. Kaneur 349	Print)  Print)  Print)  Print)  Malealm allux, N  Abarke	191hu	ntes MD	21150)
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	1 4			
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 12 8:30 2005 Virginia Eunice Cantner /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Nursing and Rehab Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Ye March 9, 7. Age (In yrs. last birthday) 1915 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 M 2 K Pennsylvania 183-01-9920 Director 90 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Mudical Examinating the modified at Annapolis Anne Arundel 1 Yes 2 No Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21403 105 Roosevelt Court death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. or the interm 27 is marked other than "natural", or ite Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: À 3 XWidowed 4 ☐ Divorced Year or Dates: white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nalda Gardiner George Edward White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 105 Roosevelt Court Annapolis, MD 21403 C. Dale Lyons/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If eny injury or once. Ft. Lincoln Cemetery 4-15-2005 <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician ementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Heat Failure **Examiner** gestine -0-Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nsequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ ₩6 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No 1□ Yes 2⊡No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DQA Nursing Home 5 Residence 6 Other (Specify) this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Hatural 5 Pending investigation i after death.

i Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical within 24 ho

To the Fun

completely f 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21441 Hulidan MD 5. ite 241 krar's Signature 31. Date filed (Month, Day, Year) 32. Reg State APR 14 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month ames /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tolcomes sastal DU 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1**⋌**M 2□F Hours 183-30-8496 66 PA Director July 18, 1938 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Exacin actinust ke ricitival at 10d. Inside City Limits Director 1 ☐ Yes 2 No Ocean City Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9962 Golf Course Rd. #21 21842 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√€ No þ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Korea Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Daley Margaret Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9962 Golf Course Rd. #21, Ocean City, Md. 21842 Marie Ann Daley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XX cremation 3 ☐ Removal from State Department of Important: If any injury or Cape Henlopen Crem. 4-15-05 Frankford, DE \* 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Ullrich Funeral Home 10902 Ocean Gateway, Berlin, Md. 21811 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lip Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Medical Certification; To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy signed by the atter Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 2 No peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 has certificate 1 ☐ Yes or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 225 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes this 27 Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29b Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State 8 2005

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Registrar

			. For	State of Maryla				d Mental Hygi	ene	•
			1 - State Registrar		Ce	rtificate of	Death		g. No. 200	5 465
	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yea	3. Time of Death
	/Medic	al	ROSE M. DOUGH	- to a second assembled		4b. City, Town, o	r Logation of D	and the second	4c. County of De	2 17:17 L
	Examin	er	4a. Facility Name (If not institution, give			Rivero		92(1)		George's
_	Funeral		Cresent Cities Nu 5. Social Security Number 6. Sex		. last birthday)	If Under 1 Year	If Under 24			Birthplace (State or Foreign Country)
	Funeral Director			M 2XIF 89	Yrs.	Months Days	Hours A	Jan. 2,	1916 Wa	shington, DC
	ō		Usual Residence of Decedent	1100 C	ity, Town or Lo	antine.				10d. Inside City Limits
	arylar show	_	10a. State 10b. County		•					1 Yes 2 □ No
	he M	Director	MD Prince Ge  10e. Street and Number	orge's Bla	adensbu	10f. Zip Code		10	g. Citizen of What	Country?
	with t			o.t		20710	1	1.0	USA	
	be filed within 72 hours after death with the Maryland tall Hygiene. Id other than "natural", or ferms 23s or 28s-f show event, It of Marical Examiner must be notified at	Funeral	5999 Emerson Stre	12. Was Decedent Ever in I	U.S. 13.			? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ar	nerican Indian,
(0)	or Iter		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No If Yes, Give		if Yes, specify Cuba 1 ☐ Yes 2 Ž No	Specify:	uerto Hican, etc.)	Black, WI	hite, etc.
ĕ	ral', c	b	3 Widowed 4 □ Divorced	Year or Dates:		10 165 220 140	эрөспу.		Specify: W	hite
5	72 h	Completed	15. Decedent's Edu (Specify only highest grade	cation e <i>completed)</i>	16a. Dece (Give	dent's Usual Occup kind of work done DO NDT use retired	ation during most of	working 1	6b. Kind of Busines	ss/Industry
121	within	d L	Elementary/Secondary (0-12)	College (1-4or 5+)		maker	-//		Own Home	
Maryland 21215-0036	Hygie ther ant,	ပိ	17. Father's Name (First, Middle, Last)		Home	marcı	18. Mother's	Name (First, Middle, M		
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ary	shou ind M mar umat	-	19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Street	and Number o	r Rural Route Number,	City or Town, State	a, Zip Code)
Ž	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or Items 23a or 28a-1 show any injury or other traumatic event, It a Marical Examiner must be notified at angle.	0000000	Barbara DeLeonibu							Maryland 21015
Baltimore,	of He of He if item		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ R	Removal from State	Place of Dispo cemetery, crea	osition (Name of matory or other place	сө)	Date 2	Oc. Location - City	or Town, State
Ě	Pag ment tant: I		* 4 ☐ Donation 5 ☐ Other (Specify)	Fo		coln Cem.		15/2005 E		
3aH	permit Depart Import any in		21. Signature of Funeral Service Licens	88				Gasch's Fu		•
	0.03 40		23a. Part1. Enter the disease, or compt	Pations that caused the dea				venue, Hyat		Approximate
			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	20.10	A	0 0			Interval Between Onset and Death
	Priysician /Medical		disease or condition resulting in death)	Due to (or as a conse	O DZZ	MOME	IMA	wordy D	neare	+
	Examiner			Proper	CVV	ne				
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):					
	cuted nd rransi	Examiner	that initiated events	c						
,092	ate be executed hysician and the burial-transit	I Ex	resulting in death) Last	Due to (or as a conse	equence of):					
6876	physic the p	dical		d						
9 X	ding iding ise as	/Me	IF FEMALE:	23c. If yes, outcome of pregr	nancy				23d. Date of d	delivery
Вох	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No}\)	1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of		□Ectopic pregnancy □ Other (specify) _	<i>'</i>		Month	Day Year
P.O.	by the	hysi	9 Unknown	9□ Unknown						
	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	Part II. Dther significant conditions con	ntributing to death but not re	sulting in the u	inderlying cause giv	ren in Part I.			lo the cause of death?
Vital Records,	w require been si should b							1	s 2 No 3	Probably 4 2 Unknown
ecc	e law r has be je 2 sh	Completed						24a. Was an autopsy	prior t	autopsy findings available to completion of cause of
<u> </u>	: The								No 1□Y	
Zita Zita	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:	7500	Oth		Death (Check only one		
oţ	Attending Physician: The Ir death. sctor: After this certificate has the funeral director, page	5	1 Yes 2 No	28a. Date of Injury	ER/Outpatie	The second second		ng Home 5 Resider		овспу)
on	nding th. :: Afte e func	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		rk? Yes 2∐No			
Division	er dear	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factory, office		28f. Location (Str. City or Town,		Rural Route Number,
ā	ital or rs afte al Dir	Cer						N. C.		<u></u>
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medicel Exami	sician: To the best of my kr iner: On the basis of examir and manner stated.	nowledge, deat nation and/or in	th occurred at the time timestigation, in my o	me, date and popinion, death of	lace, and due to the ca occurred at the time, da	use(s) and manner te and place, and d	as stated. lue to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mo	onth, Day, Year)
			A VV			14	80-	77	4/12	107
2	-(3)		30. Name and address of person who co	ompleted cause of death (Ite	em 23a) (Type,	Print)	EXAM	DER E	Z. UV	Ho
	CA	ato.	31. Date filed (Month, Day, Year)	2. Registrar's Sign	nature •	reserve		100,70	121	
	Sta Regist		APR 1 5 2005	2. Registrar's Sign	400	de la				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND#5perFH4/19/05, BW, MC State of Maryland / Department of Health and Mental Hygiene 1 - State AMEND#2, perMD4/15/05, DFS, MOCO Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 11 **Physician** NISCON HUNKIN 2245 2003 ADV. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09/15/1950 7. Age (In yrs. last birthday) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 MM 2 □ F 54 Director Delaware Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State item 27 is marked other then "natural", or items 23a or 28e-f show other traumatic event, the Neufsch Event retriebed at 1 XYes 2 No Director Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 U.S.A. 6 Tapiola Court Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: White Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Consultant Litigation Imaging 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Margaret Broderick Hopkin Morgan Davies 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6 Tapiola Court, Rockville, Maryland 20850 Christine Blakely, Companion 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If any injury or once. d 4 □ Donation 5 □ Other (Specify) Lincoln Crematory 04/15/2005 Brentwood, Maryland Ft. 22. Name and Address of Facility Simple Tribute Signature of Funeral Service Livensee 1040 Rockville Pike, Rockville, Maryland 20852 120 or complications that caused the digith. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or com shock, or heart failure. List only one cause on each line Immediate Cause (Final MASTA **Physician** TIC Week disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ь. Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Physician/Medical the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by should be 1. Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed' 2₽ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification; To filled in by the funeral 28a. Date Date f Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physicien: Hospitel

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Pages 1 and 2 s ment of Health an ant: If item 27 Is I

Baltimore, Maryland 21215-0036

State Registrar

16

Medical

29a Certifier

29b. Signature and title of certifier

A BAII

BALL

1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

162

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32. registrar's Signatury

DHMH 17 Rev 1/2001

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RUAD

29c. License number

53317

29d. Date signed (Month, Day, Year)

12

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10:45 PM Physician 04 BETTY ANN DAVIDSON 15 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner QUEEN ANNE'S CORSICA HILLS NURSING FACILITY CENTREVILLE If Under 1 Year | If Under 24 Hrs. Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number Days **Funeral** Months Hours 1 □ M 2 K F 1938 NJ 217-36-1949 67 11, Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County 28a-1 show s 23a or 28a-f shov 1 Yes 2 No Director CENTREVILLE MD QUEEN ANNE'S 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21617 2551 CHURCH HILL ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner p Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married WHITE ö 1 ☐ Yes 2 🛛 No Specify: Baltimore, Maryland 21215-0036 by 3 ☐ Widowed 4 M Divorced Year or Dates: "natural" Completed the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 11 Ith and Mental Hygier 27 Is marked other the troumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HELEN HINES JOEL THOMAS MCGINNES 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2551 CHURCH HILL ROAD, CENTREVILLE, MD nt of Health a : If item 27 la or other tree KATHY SMITH/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHESAPEAKE CREMATION
CENTER, LLC.

Date

Date

04/19/2005 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) crtment crtent: If STEVENSVILLE, MD njury permit. 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER RD., CHESTERTOWN, MD 21620 Dep mpc any aren Fellan Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. surhas, of Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? ত্ 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 🗀 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à funeral director, page 2 should be 1 ☐ Yes 2 ➡No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? certificate ! 2 No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medicai Certification: To 1 Yes 25 Mo 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Manner of Death 28b. Time of 28c. Injury at Work? After 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No М within 24 hours after death. To the Funerel Director: A 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 - Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title 30. Name and address of person who comple ted cause of death (Item 23a) (Type, Print) NLe 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

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		•	For State Registrar			-		rtificate				_	Reg. No.	200	5 1	45	60
	D		1. Decedent's Name (First, Middle,	Last)								2. Date of De.	ath Day	Yea		ime of De	eath
	Physicia /Medic		Jack	Diener								Apri1	12,	2005	1:	00 P	M
	Examin		4a. Facility Name (If not institution, g					4b. City,	Town, or	Location of	of Death		4c. 0	County of D	eath		
			5610 Wisconsin  5. Social Security Number 6	Avenue,		7 (In yrs. last birt	the day.	Che If Under		hase If Under	24 Hrs	8. Date of Birl		ontgo	mery Birthplace (	State or f	Faraira
	Funeral Director		5. Social Security Number 578-44-6538	1 <del>M</del> M 2 □ F	7. Age (		Yrs.	Months		Hours	Min.	June 2	7 Year)	01/	Country)	D. (	_
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	death with the Maryland ems 23a or 28e-f show if final be notified at	Funeral Director	10e. Street and Number 4040 Palm Aire I	orizo U	oat			10f. Zip	Code 3069				-	en of What	Country?		
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2	iled v tygie ther t		17. Father's Name (First, Middle, La	5+			Dei	ntist		18. Mothe	ar's Name	e (First, Middle,		ntal	-		
and	d be fantal head of	) Be	Hyman Diener									arter					
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or Items 23a or 28e-f show any high properties of the recomments event, the Medical Examinating the notified at angle.	10	19a. Informant's Name/Relationship	(Type, Print)	0	, 19b.	Mailir	ng Address	(Street a	and Numbe	er or Run	al Route Numbe	r, City or	Town, State	e, Zip Code,	)	- 1
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ore,	of He of He r othe		20a. Method of Disposition	•		20b. Place of	Dispo		ne of			Date			or Town, St	tate	
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Baltimore,	permit. Departimport any injustrations		21. Signature of Funeral Service Li	censee			22	2. Name an	d Addres	s of Facilit	ty	No.	1 01	-	·	107000	
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			shock, or heart failure. List or	nly one cause on	each line	beath. Don	iot eni	er the mod	e or dylni	g, such as	cardiac	or respiratory at	rest,		Interv	al Betwe	ath
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9 X	that the death certificate ed by the attending phys detached for use as the	Physician/Med	IF FEMALE:	23c. If yes, or	utcome of	f pregnancy			_				2.	3d. Date of	delivery		227
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Jo	hys his	유	1 ☐ Yes 2 X No 27. Manner of Death	28a. Date		2 □ ER/Out		- contracting	8c. Injury	4   INU	-	me 5 Resident			pecify) HC	Hest	pice-
On	ding h. After fune	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga	(Mo	nth, Day	Year) Ir	njury	м	Work	k? Yes 2□			, , ,				
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Ö	el or s afte	Certification:	4  Homicide	Dulk	oing, etc.	(Specify)						City or Tov	m, State)				
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical (	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the	e best of	my knowledge	, deat	h occurred	at the tim	ne, date an	d place,	and due to the	cause(s) a	ind manner	as stated.	ause(s)	
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			20 Name and address of annual	no completed car	150 01	alt 480m 22n) (	Tues	Drint\	1	50/14	,		чъгт.	. т+,	2005		
ó	5		30. Name and address of person w Dr. Allen A. N:						ıe, S	Suite	730	, Chevy	Cha	se, Mo	1. 208	315	
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	Regist	ar	APR 15	2005	O. A.R.	s Signature	A	SHEL)									

		State Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)	2. Date of Death	. No.	3. Time of Death
Physicia		HAZEL W. DUNNING	Month	Day Year	M
/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	April	17 200 4c. County of Dea	
		Genesis HealthCare - The Pines Easton		Talbo	t
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye		thplace (State or Foreign ountry)
Director		217-28-3205	2-25-	32   CA.	ROLINE
ryland show	_	10a. State         10b. County         10c. City, Town or Location           MD         CAROLINE         DENTON			10d. Inside City Limits
Ind 21215-0036  Ind 21215-0036  be filed within 72 hours after death with the Maryland tall Hygiene.  do other than "natural", or items 23a or 28a-t show event, the Medical Examinar must be notified at	Director		10-	Object of Minute O	1 ☐ Yes 2 📉 No
with the same of t	I Dir	106. Street and Number 10f. Zip Code 22900 DEEP BRANCH DR. 21629	109	Citizen of What Co	ountry :
death ima 2; i.mus	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spr. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
36 after or Ite		1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1 □ Yes 2 □ No Specify:	nican, etc.)	Black, Whit	
hours tural,	ed by	3 Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education   16a. Decedent's Usual Occupation	161	b. Kind of Business	LACK
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yland yland build be fill Mental Hy arked oth	Be		e (First, Middle, Mai		
force, Maryland 21215-0036 ges 1 and 2 should be lifed within 72 hours aft tof Health and Mental Hygiens, in fit item 27 is marked other than "natural; or or other traumatic event, the Medical Exami	유	HENRY WAYMAN SR. DEC MILDR  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rurs	- William - Charles		Zio Code)
Most and 2 a		GARY A. DUNNING SR. 203 PARRIS LA. EA			,
of Hear		20a. Method of Disposition  1. □ Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 200	c. Location - City or	Town, State
in Pa		'4 Donation 5 Other (Specify) SPRING GROVE CEM. 4-2	3-05 DI	ENTON MI	
Baltimore, permit. Pages 1 ar Department of Hea Important: If Item any injury or othe		21. Signature of Funeral Service Accessee 22. Name and Address of Facility			19102 - 121 Photosoft
Physician		23a. Part. Enter the disease, or compilations that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition  End - Star Vensl films			Approximate Interval Between Onset and Death USERS
/Medical Examiner		resulting in death)  a		-	1-2-
Examiner	-	Sequentially list conditions, if any leading to immediate  b.   Sequentially list conditions, if any leading to immediate.  Due 6 (or as a consequence of):			years
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  b. Dur to (or as a consequence of):  There Sclerasis, Men Rei 3 cd.  c.			years
'60, be executed sician and burial-transit		resulting in death) Last  Due to (or as a consequence of):			<i></i>
9 2 9	lcal	d			
X 68 certificateding phi	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	ivon
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. The sentificate has been signed by the attending physician to the teneral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1		Month	Day Year
cords, P. (v requires that the been signed by should be detact	by PI	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
cord			1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Munknown
Division of Vital Records, or Attending Physician: The law requires talter death.  Director: After this certificate has been signed in by the funeral director, page 2 should be a	Completed		24a. Was an autopsy performed	prior to	itopsy findings available completion of cause of
Vital Fisician: The certificate rector, page	Be	examiner?	(Check only one)		
Of Phys or this aral di	To :r	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	me 5 Residenc 28d. Describe how		cify)
inding ath.	atlor	Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S		ural Route Number,
Division of Vital Recomplete the Funest Director. Attending Physician: The law within 24 burus after death.  To the Funest Director. After this certificate has completely filled in by the funestal director, page 2		29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, check only	and due to the caus	e(s) and manner as	stated.
thin 24 thin 24 the F	Medical	29b. Signature and title of certifier 29c. License number		Date signed (Mont	
7 ¥ ¥ 5 00		230. Signature and the discontinuity ( 1000 Miles) Miles 1025933		4,18.0	
<i>F</i>					
	11	30. Name and address of person who completed cadse of death (Item 23a) (Type, Print)			

ORIGINAL

Amended Item 5 per F.D. 04/19/2005 Carroll County, wj1
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			T = For State Registrar	State o	f Marylan		artment of F		nd Me		iene 99. No. 2 0 0 5	14662
	Physici /Medic		1. Decedent's Name (First, Middle DIANE LOR		IS					2. Date of Deat		3. Time of Death 10:53 PM
	Examir		4a. Facility Name (If not institution LORIEN TANE			CENTER	4b. City, Town, o				4c. County of De.	ath
	Funeral Director		52Spoial Sporrity types 214 72 2930  Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☐ F	7. Age ( <i>In yr</i> s. 57	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, DECEME		rthplace (State or Foreign Jountry) 7 CALIFORNIA
	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28a-f ehow is Medical Exertment by relitied at	Director	10a. State 10b. County	ROLL	10c. Cit	y, Town or Lo WESTMI	NSTER					10d. Inside City Limits
	ns 23a or 3	erai Dir	102A WEST MAIN		edent Ever in U	.S. 13. \	10f. Zip Code 21157 Was Decedent of H		in? (Spec		Og. Citizen of What COUNITED ST	ATES
980	ours after d ral', or Iten	by Funeral	1 Never Married 2 Mar 3 Widowed 4 Divorced	Armed Fo 1 ☐ Yes If Yes Giv	rces? 2 XNo e	1	fYes, specify Cuba I⊡Yes 2 🛛 No	Specify:	Puerto R	lican, etc.)	Black, Wh	
21215-003	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23e or 28e-f show other traumatic event, the Medical Exert and the redilling at	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed)	-4or 5+)	(Give	lent's Usual Occup kind of work done o DO NOT use retired ANTMAL	during most ( d)		g	ANIMAL R	
Maryland 2	2 should ba filed and and Mental Hygie Is marked othar aumatic event, I	To Be Co	17. Father's Name (First, Middle, UNKNOWN)	Last)					's Name (	(First, Middle, N	Maiden Sumame)	
	and 2 shore ealth and N m 27 Is maner trauma		19a. Informant's Name/Relations WILLIAM A. LUTZ			1022	WEST MA	and Number	REET,	WESTM	City or Town, State, UNSTER, M	
altimore,	t. Page rtment o rtent: If njury or		20a. Method of Disposition  1 □ Burial 2 ▼Cremation  4 □ Donation 5 □ Other (S	Specify)	State C	RROLL C	sition (Name of natory or other place REMATION	4	Da 1/12/		20c. Location - City o	r Town, State , MARYLAND
Ba	Depa Impo eny ir		21. Signature of/Funeral Service	Q. 1/c	aused the deat	MY	. Name and Address TERS-DURB 1 WILLIS	ORAW F	UNER	WESTMIN	CIM STETE	21157 Approximate
	Physician /Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	ach line.	+25+3		3437	Cz	ner		Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	or as a conseq			·				
8760,	cate be axecuted physicien and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (	or as a conseq	uence of):						
.O. Box 6	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		irth 2 ☐ Feta ant at time of d	I death 3	Ectopic pregnancy Other (specify)				23d. Date of de Month	livery Day Year
٥.	sign sign	by	Part II. Other significant condition	ons contributing to de	eath but not res	ulting in the ur	nderlying cause give	en in Part I.		23e. Did toba		o the cause of death?
Il Records,		Completed								24a. Was an autopsy perform	ed prior to death?	utopsy findings available completion of cause of
VIII	sician s certifii irector	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hospital:	npatient 2	ER/Outpatien	Othe	ar /		Check only one		
Division of Vital	ter ner	<b>—</b>	27. Manuer of Death 1 Natural 5 Pendir 2 Accident investi	28a. Date of (Mont		28b. Time of Injury	28c. Injun Work		28		nce 6 Other (Spewinjury occurred	icity)
Divis	F 8 F C	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 286. Place buildin	ng, etc. (Specif)	y) 	et, factory, office			City or Town,	,	
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	edical	29a. Certifier 1 Certifyir (Check only 2 Medical one)	ng Physician: To the Examiner: On the ba and mann	isis of examina	wledge, death tion and/or inv	occurred at the timestigation, in my op-	ne, date and pinion, death	place, an occurred	d due to the car d at the time, da	use(s) and manner at te and place, and dur	s stated. e to the cause(s)
i	To the within to the total	Σ	29b. Signature and title of certifie	rinc fra	el ME	>	29c. License	number 2059	943		d. Date signed (Month	
	38		30. Name and address of person JOHN C. ABEL M.I		e of death (Item		SUITE 30	)7 tın	E <sup>1</sup> C'ITM #7	INCHIN	MD 2445	
••	Sta Registr		31. Date filed (Month, Day, Year) APR 1	32. R	gistrar's Signa	ture	_	<i>y</i>	<u>الإزا د</u> ب	INSTER,	MD 21157	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April Physician 2005 Gary 6:10A Lee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 815 Wakefield Valley Rd. Carroll New Windsor 8. Date of Birth (Month, Day, Year) 0ct.21, 1956 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**™**M 2□F 48 212-68-8720 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show other traumatic event, the Medical Examiner must be nutified at 1 ☐ Yes 2 No Director Maryland New Windsor Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 21776 815 Wakefield Valley Rd. U.S.A. or Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel; or lien eny injury or other traumatic event. The Medical Examiner 2008. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) farmer/breeder dairy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward N. Derr, Jr. Jean Frock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Derr/wife 815 Wakefield Valley Rd. New Windsor, MD 21776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State All County Cremation 4/12/2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 21. Signal of Fyneral Service L 22. Name and Address of Facility Hartzler Funeral Home 23a. Part1. Enter the disease, or complications that cadsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 310 Church St. New Windsor, MD 21776 Approximate Interval Between Onset and Death Immediate Cause (Final Squarous Cell Concer of the SYIN Pnysician Metastatic Syers disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ certificate has been signe rector, page 2 should be 1 ☐ Yes 2 ŒNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes 2 Z No the Hospitel or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 esidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2/E No Certification: To this Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD 038409 4/11/05 MI 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #415, Whenle 10753 FEILS Sharton William 32. Regitrar's Signature 31. Date filed (Month, Day, Year) State APR 1 3 2005 Registrar

			For State Registrar	State	of Marylan		artment of H		nd Mental H	lygien Reg. N	900	11001
	0		Decedent's Name (First, Middle	, Last)					2. Date of	Death		3. Time of Death
	Physicia /Medic		John Preston Du	ıdley, Jr					Apri		2005	10:58 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution	. 0	number)		4b. City, Town, or	Location of	Death	1	c. County of Death	
			9505 Tuckerman				Lanham				rince Geo	
	Funeral		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of (Month,	Birth Day, Year		lace (State or Foreign
	Director		217-32-4220 Usual Residence of Decedent		0,5			!	10/30/	1933	Washi	ngton, DC
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	a-f s	ctor	Maryland Prince	Georges	Lan	ham						TXTYes 2 ☐ No
	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Coun	ntry?
	s 23a	rai	9505 Tuckerman			- 1	20706			USA		
	ter de Item	Funeral Directo	11. Marital Status  1 □ Never Married 2 Marr	Armed	ecedent Ever in U. Forces? s 2	.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Orig n, Mexican,	in? (Specify Yes or Puerto Rican, etc.)	No-	<ol> <li>Race - Americ Black, White,</li> </ol>	
936	urs af	þ	3 Widowed 4 Divorced		Give Dates: '61-'	62	1 ☐ Yes 2X No	Specify:			Specify: Whit	e
Ö	2 ho	ted	15. Decedent	's Education		16a. Deced	dent's Usual Occupa	ation	-4	16b. 1	Kind of Business/Inc	
2	ithin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	T	(1-4or 5+)	life.	kind of work done o DO NOT use retired	i)	or working			
2	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f show ant, the Medical Examination rolling and		17. Father's Name (First, Middle,	(1004)		Busin	ess Owner		1- Al (F1) A f1-		olesale	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; if time 77 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be redified at once.	o Be	John P. Dudley						's Name <i>(First, Mid</i> Lillian E		,	
<u>Z</u>	shoul nd Me mark mati	T <sub>o</sub>	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street a				or Town, State, Zip	Code)
ž	alth a		Jean Dudley/ Wi	fe		1			et Lanhan	-		,
ore,	es 1 a of He of He item		20a. Method of Disposition  1 Burial 2 XCremation	2. Domewal fra	20b. P	lace of Dispo	sition (Name of natory or other place	θ)	Date	20c. L	ocation - City or To	wn, State
Ĕ	Pag ment ant; t		4 □ Donation 5 □ Other (S)		III State	ntt Cre	ematory	04	4/12/2005	Wa1	dorf, MD	
3alt	permit. Depart Import any inj once.		21. Signature of Funeral Service	Licensee 1.							ns Funera	1 Home
	70 F # 0		1276	<b>/</b>	A ( Ab d - 5 A)				Road Bow		D 20715	
F	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause of	each line.			_	VASCULO		DISIBALE	Approximate Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)		o (or as a consequ		0,100			7.1	7 1 - 6(1) 3 (	
	Examiner	_	Sequentially list conditions,	b								
	led sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	o (or as a consequ	uence of):						
	al-trar	Examiner	that initiated events resulting in death) Last	c	o (or as a consequ	uence of):						
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit			<b>L</b> d								
89	tificat ng ph) as th	Physician/Medicai										
Вох	eath certifica attending ph for use as th	an/h	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		Ectopic pregnancy				23d. Date of deliver	•
o.	the at	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pre 9□ Uni	gnant at time of de known	eath 5	Other (specify)			-	Month	Day Year
P.O.	that the de led by the a detached f	, Ph	Part II. Other significant condition	ns contributing to	death but not resu	ulting in the ur	nderlying cause give	n in Part I.	23e. Di	d tobacco	use contribute to the	e cause of death?
Division of Vital Records,	uires signi ld be	d by					, ,				N. at	abły 4 ∏Unknown
00	s been si should t	iete							24a. W	as an	24b. Were autoc	osy findings available
۾ ڇ	The lay te has	Completed								topsy rformed? 2 No	prior to con death?	npletion of cause of 2 No
ta		BeC	25. Was case referred to medical examiner?					26. Place o	of Death Check on		) 10165	20110
<u> </u>	Physic this ce al direc	2	1 ☐ Yes 2 🗷 No	Hospital: 1 [	Inpatient 2	ER/Outpatien	Othe	4 🗆 Nurs	sing Home 5X Re	sidence	6 ☐Other (Specify	)
טעס	Attending Physician: r death. ector: After this certifice by the funeral director,	ion:	27. Manner of Death  1 XNatural 5 ☐ Pending	g (Mo	e of Injury onth, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describ			
Sic	death death stor: / the fi	icat	2 Accident investig	ot be	oo of Injuny - At ho	mo form str		′es 2 □ No		(Ctroot o	nd Number or Rural	Davida Mumba
<u>`</u>	or Attency after death Director: I in by the	Certification:	4 Homicide determine	ned bui	ce of Injury - At ho Iding, etc. (Specify	()	et, lactory, office		City or	own, State	e)	Houte Number,
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifyin	g Physicien: To t	he best of my know	wledge, death	occurred at the tim	e, date and	place, and due to the	ne cause(s	) and manner as sta	ated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medicel I	exeminer: On the	basis of examinat unner stated.	ion and/or inv	estigation, in my op	inion, death	occurred at the tim	e, date an	d place, and due to	the cause(s)
,	with To t	Σ	29b. Signature and title of certifier	1118	1.		29c. License	3156	3		ite signed (Month, E	
,		,	· vwc ·	-00 ( D) 01						111	21L 12	2005
			30. Name and address of person of CHARLES M.	BENNER				DR	IVE # 205	, SI	WERSPR	NS MD
	Sta Registr		31. Date filed (Month, Day, Year)	3 2005 32.	Figistrar's Signat	ture,	book					

		•	For State	State of Ma	aryland		rtment of F		nd Men		iene	005	14665
			Registrar  1. Decedent's Name (First, Middle, L	ast)					2. [	ate of Deat			3. Time of Death
	Physici	an	GRACO P	incolore	100	F	Clin :	TI	٨	Month	Day	Year	77.48 M
	/Medic		4a. Facility Name (If not institution, g	in atmost and number	1001		4b. City/Town, o	r I ocation of I	Death	P/	4c. Cou	nty of Death	0070
	Examin	er	Language Con Color	Gon and	Low to	4	Col	1	A	*	L	to w	
			5. Social Security Number 6.	Sex 7. Ag	e (In yrs. las	st birthday)	If Under 1 Year	If Under 24	4 Hrs. 8. 0	ate of Birth			place (State or Foreign intry)
	Funeral Director		219 18 4520	373.4 o 🗆 =	80	Yrs.	Months Days	Hours	Min. De	eate of Birth Month, Day,	1924	Mai	yland
			Usual Residence of Decedent						100				-,
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Marylan f ehow	ō	MD Howard	9	E11:	icott	City						1 ☐ Yes 2X No
	or 28a-f	o_	10e. Street and Number				10f. Zip Code			1	0g. Citizen	of What Cou	intry?
	23e or	<u> </u>	8507 Chapel View	Road			2104	43			Unite	ed Sta	ates
	72 hours after death with the Maryland naturel', or Items 23e or 28e-f ehow disel Exantret must be notified at	by Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13.	Was Decedent of H	lispanic Origin	n? (Specify	Yes or No-		lace - Amer	
10	after dea or Items infraer m	Ē	1 ☐ Never Married 2 X Married	Armed Forces?			f Yes, specify Cub		Риепо ніса	n, etc.)		lack, White	, etc.
33	urs a	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1942-	45	I□Yes 🎎 No	Specify:			Spe	<sup>cify:</sup> Whi	te
5-0036	"naturel",	Completed	15. Decedent's	Education		16a. Deced	ient's Usual Occup	ation	of working		16b. Kind of	Business/i	ndustry
215	within 7. ene. then "n	pie	(Specify only highest g	College (1-4or	5+)	life. l	DO NOT use retire	d)	or working				
21	d with giene. rr ther	шо	Zioliiolitary, cocolidary (o 12)	5+		Ele	ctronics	Engine	er		West	inghou	ıse
	should be filed withir and Mental Hygiene. marked other then matic event, Ital M	Bec	17. Father's Name (First, Middle, Las	st)				18. Mother's	s Name (Fir	st, Middle, I	Maiden Sum	ame)	
<u>a</u>	Mental Merkad o	ToE	George W. Frey Si	· .				Heler	n K. B	lum			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene. Item 27 Is marked other then "naturel", or Items 23e or 28e-1 e hov other traumatic event, I've Medical Examinations to a collised a		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	g Address (Street	and Number	or Rural Ro	ute Number	City or Tov	vn, State, Z	ip Code)
Š	1 and 2 s Health an tem 27 ls i		Lola G. Frey/Wife	2		8507	Chapel V	liew Ro	oad_El	licot	t City	, MD	21043
ē	s 1 a f Hea ltern othe		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name of natory or other pla	ce)	Date		20c. Locatio	n - City or T	own, State
9	Pages net of int: If It		1 ☑ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec				ige Cemet		-18-20	05	Elkrid	dge, M	ID
Baltimore			21. Signature of Funeral Service Lic		M010		_				tzke's	Fami	ly FH Inc.
Ba	permit. Departr Importa any inji		I Thom Cilli	- attle									MD 21043
			23a. Part1. Enter the disease, or co	mplications that cause	d the death.								Approximate Interval Between
			shock, or heart failure. List on Immediate Cause (Final	ly one cause on each I	ne.			1					Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	011	M.	May	dis	yse				
	Examiner			Due to (or as	a conseque	ince (it):	/						
н		_	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a conseque	ence of):							
	ad	Examiner	cause. Enter Underlying Cause (Disease or injury		,								
	and I-trar	xan	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):							
8760,	certificate be executad nding physician and usa as the burial-transit												
87		Physician/Medical		d									
9 x	ding dang sa as	/Me	IF FEMALE:	23c. If yes, outcome	of pregnance	cv					234	Date of deli	varv
Вох	death o	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐Pregnant a	2 Fetal d	teath 3	Ectopic pregnance Other (specify)	у				Month	Day Year
Ö	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	( talle of dea	iui 5_	Cities (specify) _						
σ.	hat the double by	P	Part II. Dther significant conditions	contributing to death t	out not result	tina in the u	nderlying cause giv	en in Part I.		23e. Did tol	bacco use c	ontribute to	the cause of death?
JS,	signe	by	,	3			, ,			1 🗆 Ye	s 2 No	3 🗆 Pro	bably 4 Unknown
Vital Records,	w requires that the death certific been signed by the attending p should be detached for usa as	Completed				-				04-146	- 104	. 10/	
ec	S 53	npie								24a. Was a autops perforr	sy .	prior to c death?	opsy findings available ompletion of cause of
<u> </u>	The ate he	Sor									25/4/10		2□ No
/ita	Physician: this certific ral diractor,	Be	25. Was case referred to medical examiner?						of Death (Ch	eck only on	18)		
of \	hysia his o	2	1 ☐ Yes 2 ☐ No		ent 2 E			4 🗀 19013	sing Home				ity)
n c	ding Physician: The I h. After this certificate ha funeral diractor, page		27. Manner of Death  ↑☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry Year) 2	28b. Time o Injury	Wo			Describe no	ow injury oc	curred	
Division	endi sath. or: A he fu	sati	2 Accident investigat					Yes 2 N					
ĕ	r Att	ţij	3 Suicide 6 Could not 4 Homicide determine	28e. Place of In building, e	jury - At hom tc. <i>(Specify)</i>	ne, farm, str	eet, factory, office			Location (St City or Town		mber or Hu	ral Route Number,
D	ital o rs aff	Certification:											
	tosp t hou une une	edical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best aminer: On the basis of	of my know	ledge, deat on and/or in	n occurred at the tr vestigation, in my	me, date and opinion, death	place, and o occurred a	due to the ca t the time, d	ause(s) and ate and plac	manner as e, and due	stated. to the cause(s)
	To the Hospital or Attending within 24 hours after death.  To the Funerel Diractor: After completely filled in by the funer	ledi	one)	and manner s									, Day, Year)
	To To I	Σ	29b. Signature and title of certifier	)			29c. Licens	se number		2	JA -	neu (ועוסרונדו	, Day, rear)
			1 1 1 1 1	1 Amo	ENI	Had	4 0	415	20		De/	.15	1001
20.0			30. Name and address of person w	completed cause of	death (Item 2	23а) (Туре,	Print)	, ,	-	,	j		
100				will a	0	575	J Ces	WL	4 (	olun	6,4,	nd	21044
		ate	31. Date filed (Month, Day, Year)		rar's Signatu		/				/		
	Regist	rar	BLU TO	2005	we s	CF for	berte						

		For State Registrar	State of Maryl		epartment of H Certificate of L		-	eg. No, 🖺 🗀	1 57	1 1 pm pm pm
Physicia		1. Decedent's Name (First, Middle, Last	)	Fish			2. Date of Dea Month	th La U	Year	3. Time of Death
/Medic		George		1814			April		25	6:45A M
Examine	er	4a. Facility Name (If not institution, give				Location of Death		4c. County		
		Renaissance Garde  5. Social Security Number 6. Se		rs. last birth	Silver S		8. Date of Birth	Monte		<u>/</u>
Funeral Director		022-16-7479	M 2□F 87		rs. Months Days	Hours Min.	(Month, Day 12/18/1	Year)		lace (State or Foreign etry) achusetts
uyland show		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town	or Location			· · · · · · · · · · · · · · · · · · ·	1	Od. Inside City Limits
Ba-f s	cto	Maryland Montgome	ry S:	ilver	Spring					1 ☐ Yes 2 ☑ No
vith th	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Coun	try?
s 23	erai	3142 Gracefield Ro	12 Was Decedent Ever	n II S	20904	isnanic Origin? (Sp	ecify Yes or No-	USA 14 Baco	e - Americ	an Indian
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, If a Modical Eraphing must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	Armed Forces?  Named Forces?  Named Forces?  Named Forces?  Named Forces?  Named Forces?  Named Forces?	2-, -	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	n, Mexican, Puerto  Specify:	Rican, etc.)	Blac	k, White,	etc.
72 hour	eted t	15. Decedent's Edi (Specify only highest grad	ication	16a. i	Decedent's Usual Occupa (Give kind of work done of		ina	16b. Kind of Bu		
within and and and and and and and and and an	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retired nical Social	)		Mental 1	Hoalt	h
filed Hygid other ent, I	ပိ	17. Father's Name (First, Middle, Last)			ilear boera.	18. Mother's Name				11
Aental Aental rked c	To Be	Nathan Fishlin				Gertrude	Shapir	0		
and Nama		19a. Informant's Name/Relationship (T	ype, Print)	19b.	Mailing Address (Street a	and Number or Run	al Route Number	r, City or Town,	State, Zip	Code)
and 2 salth n 27 I		Paul Fisher -son			2 Waterfall			·		
t of Hor If iter		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ I		b. Place of i cemetery	Disposition <i>(Nam</i> e of r, c <i>rematory</i> or other plac	θ)		20c. Location -		
t. Pag rtment rtant:		` 4 □Donation 5 □ Other (Specify,	) M	etrop	olitan 22. Name and Addres		-			Virginia
Depariment Deparement Important Impo		21. Signature of Funeral Service Licens	966		7211 Lee Hr					
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the cone cause on each line.	death. Do no	ot enter the mode of dying	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	. Hetastat	7C S	quamous	s cell	cascin	oma	2	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a con							
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a con	sequence of	f):					
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.								
a exec an an irial-tr	Exa	resulting in death) Last	Due to (or as a con	sequence of	f):					
tificate be executed og physician and as the burial-transit	edical	•	d							
	-	IF FEMALE:	23c If was outcome of ore	agnancy				00   D		
To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Physician/A	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No  23c. If yes, outcome or pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)							23d. Date of delivery  Month Day Year	
d by tetach	Phy	9 ☐ Unknown  Part II. Other significant conditions co	entabuting to death but not	resulting in	the underlying cause give	an in Part I	23e Did to	nacco use conti	ribute to th	e cause of death?
n requires that the deben signed by the should be detached	ed by	Advanced	Alzheim		dement	•	1 🗆 Ye			ably 4 □Unknown
law re as be 2 sho	Completed	Hyperten	Sion				24a. Was a			osy findings available inpletion of cause of
sician: The law certificate has b irector, page 2 s	Com	01					perform	med?	leath?	2 <del>-</del> No
cian: ertific actor,	Be (	25. Was case referred to medical examiner?	11			26. Place of Deat	h (Check only on	e)		
Physician: this certific al director,	2	1 ☐ Yes 2 ☐ No  27. Manner of Death		2 ER/Outp		4 Nursing Ho	me 5 Reside			9
ding P. h. After t funera	ertification:	1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Ti	jury Work	Yes 2 No	28d. Describe ho	ow injury occurr	<b>6</b> 0	
Attendi death. ctor: A y the fu	fical	3 Suicide 6 Could not be	28e. Place of Injury -	At home, lari	m, street, factory, office		281. Location (St		er or Rura	l Route Number,
al or A after i Dire d in b	erti	4 Homicide	building, etc. (Sp	ecify)			City or Town	n, State)		
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edicai C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my iner: On the basis of exar and manner stated.	knowledge, nination and	death occurred at the tim /or investigation, in my op	ne, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) and ma ate and place, a	nner as stand due to	ated. the cause(s)
o the	Med	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed	(Month, I	Day, Year)
F 5 F ŏ		1 Lovien P	athuman	2 H	D D50	7524		livaf	11,20	505
		30. Name and address of person who o	ompleted cause of death	(Item 23a) (7	Type Print)			1		
		LOVEEN J. PUTHUN	MANA , 3110	GRA	CEFIELD RI	DAD, SIL	VER SPR	SING H	10 20	7904
Sta		31. Date filed (Month, Day, Year)  APR 1 4	32. P distrar's S	ignature M	A			•		
Registra	ell	MEN TA (	UUJ A	0 6300	Section Control of	146, 1				

		1 - For State Registrar	State of Maryland / De	epartment of Health and No Certificate of Death	•	2005 11.667	
Physici /Medic Examin	cal	1. Decedent's Name (First, Middle, Last)  EMMQ Lee  4a. Facility Name (If not institution, give s  Vulou Hos Pit	Fox street and number)	4b. City, Town, or Location of Death	2. Date of Death Month	Day Year 3. Time of Death 2 2001 5. DOAN 4c. County of Death Cecil	
Funeral Director		5. Social Security Number 6. Sex		Months Dave Hours Min	8. Date of Birth (Month, Day, Yea 7/30/1931	9. Birthplace (State or Foreig	
the Maryland 28a-f show	rector	10a. State 10b. County MD Harfo  10e. Street and Number	ord 10c. City, Town o	or Location a rlington  10f. Zip Code	100.0	10d. Inside City Limits 1 □ Yes X	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Evaning must be rediffed at once.	by Funeral Director	1707 Glen Cove  11. Marital Status  1		21034  13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto		USA  14. Race - American Indian, Black, White, etc.  Specify: White	
d 2 should be filed within 72 hours at the and Manual Hygiens 17 is marked other than "natural", or traumatic event, the Madical Exami	Completed t	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation 16a. D Completed) ((	ecedent's Usual Occupation Give kind of work done during most of work fe. DO NOT use retired) Memaker	o. Kind of Business/Industry  Own Home		
should be fill and Mental H marked ott	To Be	17. Father's Name (First, Middle, Last) Alex Hall  19a. Informant's Name/Relationship (Typ.	ne (First, Middle, Maide Quillen ral Route Number, City	en Surname) v or Town, State, Zip Code)			
oermit. Pages 1 and 2 Department of Health a mportant: If Item 27 is any injury or other tra once.		Sandra Slade/Da  20a. Method of Disposition  1 Burial 2 Cremation 3 DR	ughter 170	07 Glen Cove Road,	Darlington Date 20c.		
permit. P Departme Importan any injury once.		*4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	velido	22. Name and Address of Facility Farking Funeral Home, Inc	c.,600 Main S		
Physician /Medical /Medical /Medical /Medical /Medical /Medicial-Itaus	licai Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any leading to him ediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	Due to (or as a consequence of)  Due to (or as a consequence of)  Due to (or as a consequence of)	-dicory opathy		Approximate Interval Between Onset and Death  12 4cJ  7 deys	
To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year	
equires that en signed b	ted by Pt	Part II. Other significant conditions con	23e. Did tobacco	co use contribute to the cause of death?  2 \( \text{No} \) 3 \( \text{Probably} \) 4 \( \text{Unknown} \)			
Physician: The law r this certificate has be al director, page 2 sh		Cardiac orres.	+ ou 4/15/2005t	•	24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ N	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No	
ling Physicia n. After this certi funeral directo	lon: To Be	27. Manner of Death 1 Matural 5 Pending	ospital: 1. Impatient 2 ER/Outpa 28a. Date of Injury (Month, Day Year) Inju	atient 3 DOA Other: 4 Nursing Ho	th (Check only one) ome 5 Residence 28d. Describe how inj		
tal or Attanding Phy s after death. al Director: After this ed in by the funeral d	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined building, etc. (Specify)  M 1 Yes 2 No  28f. Location (Street and Number or Rura City or Town, State)					
To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edicai	one)	ician: To the best of my knowledge, der: On the basis of examination and/cand manner stated.	eath occurred at the time, date and place, or investigation, in my opinion, death occur	red at the time, date ar	nd place, and due to the cause(s)	
To with	W	29b. Signature and title of certifier	- MD	29c. License number 0 00 55 190	29d. D	ate signed (Month, Day, Year)	
Sta Registr	- 60	30. Name and address of person who cor  United to proceed (Month, Day, Year)		po, Print) E 1 K up 2192	1 by A1	fed A Pino ME	

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) APR 15

32. Angistrar's Signature

			For State	State of M		/ Depa	artment of F	lealth a	and M	ental Hyg	iene	156.	11.66	0
	_		Registrar  1. Decedent's Name (First, Middle, L.	ast)		- 06/	incate of	Dealii	-	2. Date of Deat	eg. No U	00	3. Time of Dear	th
	Physici	an		,						Month	Day	Year	3. Time of Deal	.n M
Š.	/Medic		Sue W. (	ingold	r)		4b. City, Town, o	r Location		APRIL 1		y of Death	9:45 A.	М.
7	Examin	er			')				OI Death					
	F		548 Longhorn Cre 5. Social Security Number 6.		ge (In yrs. Ia	st birthday)	Rockvi If Under 1 Year		24 Hrs.	8 Date of Birth	Mon	tgome	Ty_	roian
	Funeral Director			1□ M 2□ F		Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day,		1	place (State or For ntry)	ыуп
			Usual Residence of Decedent		87					March 1	8, 1917	3 Ne	w York	
	yłanc wor		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Lin	
	Mar Set	tor	Maryland Montgom	10 <b>~</b> 37	Po	ckvil	1.0						1 ☐ Yes 2 ☐	No
	r 28	irec	10e. Street and Number	<u> </u>	100	CRVII	10f. Zip Code			1	0g. Citizen of	What Cour	ntry?	
	n 72 hours after death with the Maryland "natural", or Items 23a or 28e-f show edical Evacilier met be neditied at	Funeral Director	548 Longhorn Cres	cent			20850			į	U. S	. A.		
	deal	ner	11. Marital Status	12. Was Deceden Armed Forces			Was Decedent of H	lispanic Or	rigin? (Spec	cify Yes or No-		ce - Americ		
٥	after or Ite		1 ☐ Never Married 2 ☐ Married	1 Tes 2 If Yes, Give			1 ☐ Yes 2 ☐XNo	Specify:		nican, etc.)		ick, White,		
215-0036	ours raf.	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:	:		165 2140	эрвспу.			Specia	fy: Wh	ite	
ה	i within 72 ho jene. r than "natu	ompieted	15. Decedent's E (Specify only highest gi	ducation ade completed)		16a. Dece	dent's Usual Occup	ation during mos	st of workin	a I	16b. Kind of B	Jusiness/In	dustry	
7	within 72 ene. than "nai	пр	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done DO NOT use retired	d)						
N.	filed w Hygier ther th	S	12 Years			Ho	memaker				Own I			
2	_ 0 9	Be	17. Father's Name (First, Middle, Las	1)						(First, Middle, M		ne)		
<u> </u>		은	Sidney Werner							labodia				
			19a. Informant's Name/Relationship		_		ng Address (Street							
≥ .	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		Patricia W. Berge	nrieid-Dg			Longhorn							
Baltimore,	of H of H if Ite		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3	Removal from State	20b. Pla cer	ice of Dispo metery, crer	sition (Name of natory or other plac	ce)	Da	ate	20c. Location	- City or To	own, State	
Ě	Pag ment ant: ury		`4 ☐Donation 5 ☐ Other (Spec		Bet	h Dav	id Cemete	ery 4	4/15/2	2005	Elmont,	, L.	I., N. Yo	ork
ait	aparti aport ny inj		21. Signature of Funeral Service Lice	/ 14		D. 22	. Name and Addre anzansky-	ss of Facili	ity	Memoria	l Chane	10	Inc	
13	E & # 0 E		Donald .	Xtoti	Temy	es	70 Rocky	ille	Pike.	. Rocky	ille. N	/arv1	and 20853	2
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that cause	ed the de	Do not ent	er the mode of dyin	ng, such as	cardiac or	respiratory arre	est,	1	Approximate Interval Between	
1	Physician		Immediate Cause (Final disease or condition	Chro	nio Ob	etrue	tive Lung	Dies					Onset and Death	
	/Medical		resulting in death)	Due to (or a	s a conseque	ence of):	rive rung	DISC	iasc				Years	
	Examiner		Conventially list conditions	b										
	n =	ner	Sequentially list conditions, if any, leading to immediate gauce. Enter Underlying	Due to (or as	s a conseque	ence of):								
	cuter nd ransi	Examiner	that initiated events	С.										
ĵ.	be executed ician and burial-transit	EX	resulting in death) Last	Due to (or a	s a conseque	ence of):								
1/90	cate be executed physician and the burial-transit	icai		_ d										
õ	death certificate e attending phys d for use as the	Physician/Med	IT FOMALO.											
X Q Q	th ce endii r use	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom- 1 ☐ Live birth			Ectopic pregnancy	,				ate of delive		- 1
, D	dea ne att	sicia	in the past 12 months?	4☐Pregnant a			Other (specify)				Mo	onth	Day Year	- 8
J.	at the by the	hy	9 🗆 Unknown											
- Ś	law requires that the de as been signed by the 2 should be detached	by F	Part II. Other significant conditions		but not result	ting in the ui	nderlying cause giv	en in Part I	i.	23e. Did tob	acco use con	tribute to th	ne cause of death?	
cords,	aquir en si ould l		Parkinson's D	ısease						1 □ Ye	s 2 No	3 Prob	ably 4 Unkno	wn
ပိ	law re as be 2 sho	piet	Hypertension  Hypeslipidemi							24a. Was ar	24b.	Were auto	psy findings availa	bie
ř	The I	Completed	nypesiipidemi	a						autopsy perform	red?	death?	mpletion of cause	10
	ician: The lav certificate has ector, page 2	0	25. Was case referred to medical					26. Place	e of Death	1 □ Yes 2 (Check only one		10103	2010	
>	ysici is cer direc	0 8	examiner? 1 □ Yes _ 2 🏋 No	Hospital: 1 ☐ Inpat	ient 2 🗆 El	R/Outpatien	t 3 DOA Oth					ier (Specifi	Hospice	
0	g Ph er th seral	n:T	27. Manner of Death	28a. Date of Inj (Month, D	jury 2	28b. Time of Injury				3d. Describe ho			., .	
IVISION	ndin ath. r: Aft	ertification:	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		ay reary	injury		Yes 2	No					
<u>s</u>	Atte	ific	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	289. Place of in	njury - At hom	ne, farm, str	eet, factory, office		28	Bf. Location (Str	eet and Numb	oer or Rura	l Route Number,	
5	s afte	Cert		building, 6	etc. (Specify)					City or Town	, Jiaiej			
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director; is		29a. Certifier 1X Certifying P	hysician: To the bes	t of my knowl	ledge, death	occurred at the tin	ne, date an	nd place, ar	nd due to the ca	use(s) and ma	anner as st	ated.	
	n 24 n 24 ne Fu	edicai	(Check only 2 Medical Exa	miner: On the basis and manner's	of examinatio	on and/or inv	estigation, in my o	pinion, dea	ath occurred	d at the time, da	te and place,	and due to	the cause(s)	
	To the To the Comp	ğ	29b. Signature and title of certifier				29c. License	e number		29	d. Date signe	d (Month, )	Day, Year)	
			V/19				Do	05949	9		April	16 2	2005	
	6		30. Name and addreg of paysor who	completed cause of	death (Item 2	23a) (Type.		33377	_		TALLE	<b>17,</b> 2	.003	
	G		Dr. Mary E. Ca					d, Su	ite 3	00, Roc	kville	, Md.	20852	
	Sta	te	31. Date filed (Month, Day, Year)	22 <b>D</b> 6 piet	trada Cianatu		-			, 2.0		,	_5552	
	Registr	ar	APR 15	2005	was Signatu	T. Sop	134L							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 1:40 P. M Kenneth L. Harris April 6. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bel Pre Nursing Home And Rehabilitation Center SIIverSpring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 □ F 521-88-5403 47 Yrs Director December 26. 1957 North Carolina Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28e-f show Examiner must be notified at 1 AYes 2 No Director Delaware Kent Dover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 286 Scotch Pine Drive 19901 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: Black "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Unemployed N/A 12th grade permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence B. Harris Amie Bailev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Lawrence B. Harris (Father) 286 Scotch Pine Drive Dover, Delaware 19901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory, Inc. APril 14, 2015 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hint Place, N.E. Washington, D.C. 20019 Part1. Ent the disease, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final Physician Anoxic Encephalopathy disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Intraventricular Hammonhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and al-transit The law requires that the death certificate be executed Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XXo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed 1 Yes 2 XNo 1 ☐ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 XNursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√√No 10 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation after death. | Director: Al 1 TYes 2 □ No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D Hospital 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D050545 April 14, 2005 66 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Codswill O. Okoji, M.D. 7513 New Hampshire Avenue Takoma Park, Maryland 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 8 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Denise Apri1 Dorsey Hansen 17, 2005 1:45 p.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center St. Mary's <u>Leonardtown</u> If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗷 F Yrs. Director 58 217-44-6713 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "natural", or Itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Tyes 2 No Directo Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25138 Gallant Man Drive 20636 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene is marked other than "natural", or item 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 PNo Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be flik Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event any Injury or other traumatic event anse. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Gantt Dorsev <u>Veronica</u> Dilworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie R. Hansen / Husband 25138 Gallant Man Drive, Hollywood, MD 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 de Cremation 3 ☐ Removal from State Brinsfield-Echols Cr. 4-23-2005 Charlotte Hall, MD ` 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Schule Linesee Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Carcinomatosis disease or condition resulting in death) months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Pancreatic Cancer vear Due to (or as a consequence of): Examine use as the burial-transit resulting in death) Last Due to (or as a consequence of): the attending physician P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ■ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 2 1 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 29a. Certifier 1 @ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Dav. Year) emes D06419 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) M./D., 24035 Three Notch Road, Hollywood, Maryland 20636 J. Patrick Jarboe,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Herman E. Harrod, Jr. April 2005 4:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Prince George's Cheverly If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ MM 2 □ F Director 578-66-7538 55 Sep. 19, 1949 Wash., DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinar must be multired at 1 XYes 2 No Director Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 3201 Reed St., #2921 20706 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12th Department of Public Work City Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Herman E. Harrod, Sr. Irene E. Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traum once. Cheryl Harrod - Wife 3201 Reed St., #2921 Lanham, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 4/18/2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD 22. Name and Address of Facility Stewart Funeral Home 21. Signa re of Funeral Service Licensee rows 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part 1 Inter the disease, or complications that caused the death. Do not enler the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximale Interval Between Onset and Death Immediate Ca se (Final disease or an dition Physician Metabolic Acidosis resulting in death /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, y add g to the sould cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed use as the burial-transit been signed by the attending physiclan and should be detached for נוגם אג יוים באי יהיים והיים! that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabetes, Chronic Diarrhea 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Decubitus Ulcer, Alcohol Hepatitis page performed? Yes 2 4No Left Lower Leg Amuputation 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After thir funeral c 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral ( 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Dev. Year) D52430 April 15, 2005 who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive, Cheverly, MD 20785 Dr. Rosaline Fraser 31. Date filed (Month, Day, Year) . Registrar's Signature State APR 1 8 2005 Registrar

		•	For State Registrar	State of Maryl	and / Dep			Mental Hy	•	15 11.	070		
	Division		1. Decedent's Name (First, Middle, Las	()				2. Date of De	aath		e of Death		
	Physicia /Medic		Joseph H	aynes				April	13 2	Year 005 3:	30P M		
,	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town	or Location of Deat	h	4c. County				
			1304 Ringbell Loo			LArgo				e Georges			
	Funeral Director		5. Social Security Number 718-14-6600 6. Security Number 718-14-6600	X M 2□F 7. Age (In )	vrs. last birthday, Yrs.	If Under 1 Yea Months Day		8. Date of Bir (Month, Da June 2	ay, Year)	9. Birthplace (State Country) Georgia	te or Foreign		
	/land		10a. State 10b. County	100	City, Town or L	ocation				10d. Inside	City Limits		
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	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	Vhat Country?			
	th wi		1304 Ring Bell Lo	ор		20774			USA				
	eems erri	Funerai	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No	- 14. Race	e - American Indian k, White, etc.	,		
36	or lit	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔀 No If Yes, Give		1 ☐ Yes 2 🕱 N		, ,		Black			
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9			17. Father's Name (First, Middle, Last)		ria.	Intellanc		me (First, Middle	, Maiden Surnam				
Maryland	shoutd be ind Mentail Ind Mentail Individued of	To Be	Unknown				Unk	nown		·			
ary.	should and Men is marke eumatic	<b> </b>	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ing Address (Stre	et and Number or R	ural Route Numb	er, City or Town,	State, Zip Code)			
	0 0 0		Carolyn Berrian/G	randdaughter			11 Loop,						
e,	of Health item 27	Ì	20a. Method of Disposition		b. Place of Disp	osition (Name of matory or other p	lacel	Date	20c. Location -	City or Town, State			
Baltimore,	g		1 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	ort Lin			8-05	Brentwoo	od. MD.			
a	in part		21. Signature of Funeral Service Licen				ress of Facility Ma						
m	Dep imp any		STP may	shall			St. N.W.						
	Ph sician /Medical Examiner		23a. Partt_Enter No disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Atherosc Due to (or as a con	erotic				rrest,	Approxin Interval E Onset ar	Between		
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Examiner	d										
O. Box 6	it the death certifica by the attending phi tached for use as th				ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	□Ectopic pregnar □ Other (specify)	су		23d. Date Mon	e of delivery hth Day
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I Records,		Completed						24a. Was auto perfo	psy pormed? d	Vere autopsy finding rior to completion of leath?	gs available of cause of		
Vital	Physicien: r this certific ral director,	Be (	25. Was case referred to medical examiner?	in the state of th				ath (Check only o					
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sion o	Attending P r death. ector: After t by the funera	ation:	27. Manner of Death  1 ☒ Natural 5 ☐ Pending  2 ☐ Accident investigation		r) 28b. Time of Injury	W	ury at ork? Yes 2 No	28d. Describe	how injury occurre	ed			
Division	F S F F	Certification:	3 Suicide 6 Could not be determined				City or To	wn, State)	er or Rural Route N	umber,			
	To the Hoepitel of within 24 hours of To the Funerel D completely filled in	<b>l</b> edical	(Check only 2   Medical Exam	ysician: To the best of my iner: On the basis of exar and manner stated.	knowledge, deai nination and/or in	vestigation, in my	opinion, death occu	a, and due to the urred at the time,	date and place, a	ind due to the cause			
)	or with	M	29b. Signature and title of certifier	Lung	m	D32	nse number 261		29d. Date signed April 14	, 2005	")		
	(10)		30. Name an address of person who Richard J. Felon	nan, M.D. 950	00 Annap	olis Roa	d Suite A	-4 Lanh	am, MD.	20706			
	Sta Registr		31. Date filed (Month, Day, Year)  APR 1 5 200	37 Registrar's S	ignature	will							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death **Physician** Frank Hartman, Jr. April 2005 2:45 p.m. /Medical 13 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 75 Palmsetta Court Westminster Carroll 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Funeral 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1**√**2 M 2□ F Months Hours 72 Director 14 1932 212-28-7888 MD the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 la marked other than "natural", or Itams 23a or 28a-f show other traumatic event. The Madical Examiner must be notified at Carroll Westminster 1 ☐ Yes 2 ☑ No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 75 Palmsetta Court 21157 death USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after dean Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" once. 12. Was Decedent Ever in U.S. Armed Forces? No 195 No 195 If Yes, Give Year or Dates: 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1951 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 1952 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Ingleside Plumbing & 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Heating Company 12 Plumber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Catherine Stevenson 0 Frank Hartman, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann R. Hartman/wife 75 Palmsetta Court Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 □Donation 5 □Other (Specify) Baltimore, MD New Cathedral Cemetery 4/16/2005 22. Name and Address of Facility
Pritts Funeral Home and Chapel, P.A. 21. Signature of Funeral Service Licenses 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final) 21157 Approximate Interval Between Onset and Death Immediate Cause (Final Carcinoid Pnysician etastance Jumoy MERTS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a sonsequence of Examiner the attending physician and the for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ ate has been signa page 2 should be 1 Yes 2 No 3 Probably 4 Minknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 2 100 Division of Vital 1 ☐ Yes To the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 1 ☐ Yes 2 ☐ No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No after death. 2 Accident investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D52035 MD 2005 MSL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

APR 1 5 2005

CHACKO

31. Date filed (Month, Day, Year)

291

32. Registrar's Signature

Avenue

Stoner

Gentminista

MO 21157

			State of Maryland / Dep	partment of Health and Mental Hygie ertificate of Death	ne 2005 11.675
	Physicia /Medic Examin	an al	Decedent's Name (First, Middle, Last)  ALBERTA ELIZABET  4a. Facility Name (If not institution, give street and number)  LOOKABOUT MANOR	TH HOPKINS  2. Date of Death Month APRIL 1  4b. City, Town, or Location of Death WESTMINSTER	Day Year 3. Time of Death 3, 2005 8:15 A M 4c. County of Death CARROLL
	Funeral Director		5. Social Security Number  218-20-2319  6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 M 2 F 93 Yrs.  Usual Residence of Decedent		ear) 9. Birthplace (State or Foreign Country) MARYLAND
	ne Maryland 8e-f show	ctor	10a. State         10b. County         10c. City, Town or I           MD         CARROLL         WESTM	INSTER	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	death with the ms 23a or 2	neral Dire	10e. Street and Number  341 W. DEEP RUN RD.  11. Marital Status 12. Was Decedent Ever in U.S. 13	10f. Zip Code 10g 21158  Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Citizen of What Country?  USA  14. Race - American Indian,
-0036	hours after turel', or Ite	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ∑ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:	Black, White, etc.  Specify: WHITE  b. Kind of Business/Industry
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-f show amy righty or other treumatic event. It is Madical Exacultier must be notified at anone.	Complet	(Specify only highest grade completed)  Elementary/Secondary (0-12)  1 2  (Giv life. 2)  College (1-4or 5+)  2	re kind of work done during most of working DO NOT use retired) NURSE	HEALTH
aryland	should be fi nd Mental H marked otl umatic ever	To Be	17. Father's Name (First, Middle, Last)  WILLARD LEVERTON  19a. Informant's Name/Relationship (Type, Print)  19b. Mai	FRAMPTON ALVERTA  iling Address (Street and Number or Rural Route Number, C	DAVIS
ore, Ma	ges 1 and 2 t of Health a if item 27 is or other tre		20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition cemetery, or	ematory or other place)	c. Location - City or Town, State
Baltimore,	permit. Pa Departmen Importent: any injury once.		21. Signal Fun (al Service Licensee	FAMILY CEM. 4/18/05 SE 22. Name and Address of Facility FLETCHER F 54 E. MAIN ST., WESTMINS	
	Pnysician /Medical		23a. Part1. Erite the disease, or complications that caused the death. Do not e shock, of flear failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	nter the mode of dying, such as cardiac or respiratory arrest $_{\mathcal{A}}  under \mathcal{K}$	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or high).		
8760,	icate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last  c. Due to (or as a consequence of):  d.		
.O. Box 68	death certif e attending d for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
۵.	The law requires that the tte has been signed by thogge 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	, ,	cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown
Vital Records,		e Completed	25. Was case referred to medical	24a. Was an autopsy performe 1 ☐ Yes 2 2 25. Place of Death (Check only one)	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No
of	Phys this ral dia	lon: To B	examiner? 1   Yes   2   No	ent 3 DOA Other: 4 Nursing Home 5 Residence of 28c. Injury at 28d. Describe how	100
Division	or Atten ifter deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)		et and Number or Rural Route Number, State)
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, de 2. Medical Examiner: On the basis of examination and/or and manner stated.  29b. Signature and title of certifier	investigation, in my opinion, death occurred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)  . Date signed (Month, Day, Year)
	WIL S		30. Name and address of person who completed cause of death (Item 23a) (Typ		04-15-2005
• 4	Sta Regist		PHILIP J. RUZBARSKY, MD 125 A: 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 15 2005	IRPORT DR., WESTMINSTER	, MD. 21158
			11. 20 200 /000		

death with the Maryland

Show

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Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Ie marked other then "netural", or Itei

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2:22 David Arnold Hughes Рм 2005 /Medical APRIL 9 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LAUREL REGIONAL HOSPITAL LAUREL PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10-24-1964 Birthplace (State or Foreign Country) **Funeral** 1**√** M 2□ F Months 40 Director 217-72-8939 Washington, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 □ Yes 2 No Completed by Funeral Director Beltsville Maryland Prince George's 10e. Street and Number 10g. Citizen of What Country? 11221 Dorset Lane 20705 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) O Disabled N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Kenneth A. Hughes Margaret L. Spooner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin M. Sexton/ Sister 2330 Putnam Lane, Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) ö permit. Page Department of Important: If eny injury or once. 4-12-05 Edgewater, MD Kalas Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** choking /Medical Due to (or as a const Examiner rord bolus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🗖 No 3 Probably 4 ☐Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of director, page 2 autopsy performed? death? 1 Yes 2 🗆 No 2 No 25. Was case referred to medical 26. Place of Death Check on one examiner1 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1X Yes 2 □ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28d. Discribe how injury occurred

28d. Location (Street and Number or Rural Route Number, Cayor Town, Mata) 28a. Date of Injury (Morth, Day Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 9-05 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 13:45 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 / Homicide DU DUNG as ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only

The law requires that the death certificate be executed has the Hospitel or Attending Physicien: After death. after death Director: within 24 hours To the Funerel

> State Registrar

31. Date filed (Month, Day, Year) APR 14 2005

30 Name and address of perspn who completed cause of

1.01

onel

29b. Signature and title of certifier

Mac

111 Penn Street Baltimore, Maryland 21201

29c. License number

OCME

29d. Date signed (Month, Day, Year)

APRIL 11, 2005

			1 - For State of Maryland / Department of Health and Me Certificate of Death		ne No. 2005	14677
	Physic /Medi Examii	cal	BEATRICE BESSIE LAMBERTSON JOSEPH  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	April 1	Day Year 6, 2005 4c. County of Death	3. Time of Death 4:35 p
	Funeral Director		32730 Costen Road  5. Social Security Number 215-18-4096  Usual Residence of Decedent  Westover  7. Age (In yrs. last birthday) 85 Yrs.  Westover  If Under 1 Year If Under 24 Hrs. Months Days Hours Min. J	8. Date of Birth (Month, Day, Ye	Somerset 9. Binho Cour 1919 Mary	olace (State or Foreign htry) land
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinational Landilled at	Funeral Director	10a. State 10b. County 10c. City, Town or Location  MD Somerset Westover  10e. Street and Number 10f. Zip Code  32730 Costen Road 21871  11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No 10c. City, Town or Location  Westover 10f. Zip Code 21871  1 Never Married 2 No 10c. City, Town or Location  10c. City, Town or Location  10f. Zip Code 21871  11. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rie		Citizen of What Cour  USA  14. Race - Americ Black, White,	an Indian,
2121 ad within	filed within 72 hours af Hygiene. yther than "natural", or ant, the Medical Exem	Completed by		F	in Kind of Business/Ind	
re, Maryland	1 and 2 should be Health and Mental Iem 27 is marked o	To Be	Raymond Lambertson  19a. Informant's Name/Relationship (Type, Print)  Thomas C. Joseph (husband)  20a. Method of Disposition  20b. Place of Disposition (Name of Date of Disposition (Name of Date of Disposition (Name of Date of Disposition (Name of Date of Disposition (Name of Date of Disposition (Name of Date of Disposition (Name of Date of Disposition (Name of Date of Date of Disposition (Name of Date of Disposition (Name of Date of	oston Route Number, Cit over, MD	ty or Town, State, Zip	
Baltimore,	permit. Pages Department of Importent: If it any injury or o		**Burial 2   Cremation 3   Removal from State  *4   Donation 5   Other (Specify)  21. Signature of Fundal Service Licensee  **Mark's Foiscopal Cemetery  22. Name and Address of Facility  Holloway Melson Fundal Service Licensee  103 Linden Ave., Pos	We:	stover, Ma	aryland
	death certificate be executed  Water direction and the purish fransit and the burial-transit and the purish transit  cal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respect to the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	respiratory arrest,		Approximate Interval Between Onset and Death  5 - www.	
.O. Box 68	death certific e attending p d for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delive Month	ry Day Year
Records, P.	aw requires tha Is been signed 2 should be det	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Ves 24a. Was an autopsy	prior to con	
vision of Vital	Attending Physician: r death. ector: After this certifics by the funeral director, p	Certification; To Be Cor	27. Mannayof Death  1	performed?   death?   1   Yes 2   No   2   No   2   No   2   No   2   No   2   No   3   No   5   Residence 6   Other (Specify)   5   Describe how injury occurred  Location (Street and Number or Rural Route Number, City or Town, State)		
Q	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b.	Medical Cer	29a. Certiflier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  29b. Signature and title of certified  29c. License number	d due to the cause at the time, date a	(s) and manner as stand place, and due to  Date signed (Month, E	the cause(s)  Day, Year)
H	, §		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  1604-Naket St., Ocomoke, MD  31. Date filed (Month, Day, Year)  APR 18 2005  32. Egistrar's Signature	2/2	851	
	Regist	rar	WLK TO COOR			

_		1 - State Registrar		1arylan		artment of F rtificate of			Reg. No. 2	005	1467
Physici	ian	Decedent's Name (First, Middle,     Grace Jackson	•					2. Date of De Month	ath Day	Year	3. Time of Death
/Media	cal			-1		41. Oh. T	.1	April_	07	2005	4:05 A
Examir	ner	4a. Facility Name (If not institution,		7)		4b. City, Town, o	Spring	ath		nty of Death	2.17
Funeral		Manor Care Silv  5. Social Security Number		ge (In yrs.	last birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Bir			
Director		578-22-0002 Usuel Residence of Decedent	1□M 2ØF	92	Yrs.	Months Days	Hours M	in. 8. Date of Bir (Month, Da June 29	y, Year) , 1912	Vir	plece (State or Foreigntry) ginia
rylan		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				1	0d. Inside City Limit
permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-1 show any injury or other traumatic event, If a Medical Examition must be rediffied at ODGE.	cto	MD Montgo	mery	Si	lver S	pring					1X Yes 2 □ No
	Dire	10e. Street and Number		10f. Zip Code					10g. Citizen	of What Cour	ntry?
ath v	ia	2201 Colston				20910			USA		
rs after de I', or Item	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marrie  3 ☑ Widowed 4 □ Divorced	12. Was Deceden Armed Forces  1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	? ] No		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🕱 No	dispanic Origin? an, Mexican, Pu Specity:	(Specify Yes or No erto Rican, etc.)		Race - Americ Black, White, Incify: Bla	etc.
2 hou	ed	15. Decedent's	Education		16a. Dece	dent's Usual Occup	pation		16b. Kind of	f Business/Inc	
hin 7:	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	5.41	(Give	kind of work done DO NOT use retire	during most of w	vorking			Suotry
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uld be file Mental Hy irked oth	To Be (	17. Father's Name (First, Middle, La Stanhope Dodsor	,					lame <i>(First, Middle,</i> Spencer	Maiden Sum	name)	
ind 2 sho alth and I 27 Is me or traume		19a. Informant's Name/Relationshi						Rural Route Numbe Lanham			Code)
of He		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of matory or other place		Date		n - City or To	wn, State
Pege nent ant: If		1 ☑Bunal 2 ☐ Cremation 3 1 ☐ Donetion 5 ☐ Other (Spe				[emorial		2-05	Suit1	and, M	D.
permit. Departr Imports any inju		21. Signature of Funeral Service Li	ensee lall.					ershall's Washing			
-		23a. Part. Enter the disease, or or shock, or heart failure. List or	omplications that cause	d the deat							Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Sepsis								Onset and Death
/Medical		resulting in death)	Due to (or a		uence of):						4 days
Examiner		Sequentially list conditions	Recurr	ent P	neumon	ia					2 wks.
ס אַ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events)  Recurrent Urinary Tract Infection									
be execute icien and burial-trans	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Recurr			Tract I	nfection	1			2 wks.
phys phys s the			d								
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending physicien and papelled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N							23d. Date of delivery  Month Day Year	
that t ed by detac		Part II. Other significant condition	contributing to death	but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use co	ontribute to th	e cause of death?
sign sign d be	d by	Dysphagia	1,00			, , ,					ably 42 Unknown
w require been si should I	ete	Decubitus									
Physiclen: The law r this certificate has ral director, page 2 a	Completed	Decapicas							sy med?	prior to con death?	osy findings available apletion of cause of
an: tifica tor, p	e e	25. Was case referred to medical					26 Place of D	1 ☐ Yes eath (Check only o		1 🗌 Yes	2 No
ysicl is cer direc	O B	examiner? 1 ☐ Yes 2 ②XNo	Hospital:	ient 2 🗆	ER/Outpatien	t 3 DOA Oth	0.0	Home 5 ☐ Resid		ther (Specify	r)
iding Ph th. : After th funeral	tion: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Inj (Month, D	ury ay Year)	28b. Time of Injury	28c. Injun Wor	/ at	28d. Describe h			/
To the Hospitel or Attendir within 24 hours after death.  To the Funeral Director: Algorithm of the fulled in by the fulled in by the fulled in the fulled i	ertification:	3 Suicide 6 Could no determin	be 28e. Place of Ir	njury - At ho	ome, farm, str	eet, factory, office		28f. Location (S City or Tow		mber or Rural	Route Number,
To the Hospitel or within 24 hours after To the Funeral Dir	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the bes aminer: On the basis and manner s	of examinal	wledge, death tion and/or inv	occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	ce, and due to the courred at the time, of	ause(s) and i	manner as sta e, and due to	ated. the cause(s)
ro th Mithin Fo th Rempl	Me	29b. Signature and title of certifier				29c. Licens			29d. Date sign	ned (Month, L	Day, Year)
10	1	> Ala	0.:			Di 9	609		An= - 1	10 01	205
		30. Name and address of person wh	o completed cause of	death (Item	23a) (Type		· ·		April	18, 20	JU5
50 6	o of a deposit of the last	Raman Tuli, M.					e 202 G	aitherch	ro Ma	1. 200	7 Ω
	ite	31. Date filed (Month, Day, Year)	A 32. Regist	rar's Signa	ture				6 TIU	200/	U

		1 - For State Registrar	State of Maryla		artment of F			giene Beg. No. 05	14680	
		Decedent's Name (First, Middle, Last)				-	2. Date of De	ath	3. Time of Death	
Physici /Medi		Nevada Barbara Jus	tice				April 1	4, 2005 Yes	2:10 PM M	
Examir		4a. Facility Name (If not institution, give			4b. City, Town, o		eath	4c. County of D		
		Westminster Nursin	g and Rehabi	litatio	n Westmi	nster		Carrol1		
Funeral		Social Security Number     6. Sex		. last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Bir Min. (Month, Da	th 9.1	Birthplace (State or Foreign Country)	
Director		210-20-2023	<sup>1M 2</sup> <b>□</b> 73	Yrs.	Months Bays	l louis l		26, 1931	Maryland	
pu s		Usuel Residence of Decedent  10a. State 10b. County	100.0	ity, Town or Lo	ocation				10d. Inside City Limits	
sho	ō				Journal				1 ☐ Yes 2 ☑ No	
28a-1	Director	MD Carroll  10e. Street and Number	Mt	. Airy	10f. Zip Code			10- Citizen of Miles		
with	Ö				Tot. Zip Code			10g. Citizen of What		
eath	era	2137 Flagmarsh Rd.	12. Was Decedent Ever in	15 13	Was Decedent of I	Hispanic Origin	? (Specify Yes or No	United St	merican Indian,	
fter d	Funerai	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 1 No	10.	If Yes, specify Cub	an, Mexican, P	uerto Rican, etc.)	Black, W		
urs at	þ	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify:	White	
72 hours after death with the Maryland natural; or teme 23a or 28a-1 show dicul Exami, nor must be to diffed at	Completed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occul	pation		16b. Kind of Busine	ss/industry	
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be filed tal Hygi d other	Be (	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	, Maiden Surname)		
should be ind Mental marked o	10	George Lester Smit	h			Gladys	Mae Ledf	ord		
2 should be and Mental is marked eumatic ev		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Street	t and Number o	r Rural Route Numb	er, City or Town, Stat	e, Zip Code)	
of Heelth of Heelth Item 27 I		Carrie I. Ecker (s		2128	Paddock :	Lane Fi	nksburg. ]	MD 21048		
ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Heelth and Mental Hygiene. It of Heelth and Mental Hygiene. It filem 27 is marked other than "natural", or Itame 23a or 28a-1 show or other treumatic event, the Medicul Evant nor invalle to rottlind at		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		Place of Dispo cemetery, cre-	osition (Name of matory or other pla	108)	Date	20c. Location - City	or Town, State	
Pag ment ent; I		`4 □ Donation 5 □ Other (Specify)		lar Sp	rings Cem	n. 4/18	8/2005	Poplar Sp:	rings MD	
permit. Pages i Department of h Importent; if ite any injury or ot once.		21. Signature of Funeral Service Licens		2	2. Name and Addre	ess of Facility		5.5		
82589		fold like		12	12 W. 01	een run d Liber	rty Rd. W	and Crema infield, M	tory, P.A. D 21784	
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the dea	ath. Do not en	ter the mode of dyi	ng, such as car	rdiac or respiratory a	rrest,	Approximate Interval Between	
Pnysician		Immediate Cause (Final disease or condition		27 76 177			O P		Onset and Death	
/Medical		resulting in death)	Due to (or as a conse	quence of):		crico	6 10	2000		
Examiner		Sequentially list conditions	CO	PN					- coman - co	
₽ #	ner	Tany leading to in recliate cause. Enter Underlying	Due to (or as a cons	quence 11:				***************************************		
acute nd trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):								
e exe ian a urial-	Ä	resulting in death) cast								
cate be executed physician and the burial-transit	dicai	d. D.V.T								
eath certific ettending p for use as i		IF FEMALE:						10.00		
the death certifi y the ettending ached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	al death 3	□Ectopic pregnanc	;y		23d. Date of Month	delivery Day Year	
e deg	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown	death 5	Other (specify)			Month Day		
that the de led by the e detached t	Ph		- talk utilan to along his but on the	autia ia tha c		in Danii	220 Did 8	obassaa saataibaa	and the server of death?	
Se Se	by	Part II. Other significant conditions co.	mibating to death but not re	sulling in the t	inderlying cause gr	ven in Part I.	230. Did t		e to the cause of death?	
w requir been sl should	ted							res 2 No 3	Probably 4 Unknown	
e law has b	ompieted						24a. Was	psy prior	autopsy findings available to completion of cause of	
	Con						1 ☐ Yes	ormed? death		
icien: 1 certificat	Be	25. Was case referred to medical examiner?					Death (Check only of	one)		
Physicien: this certific al director.	2	1 ☐ Yes 2 ☐ HO		☐ ER/Outpatie	nt 3L DOA	her: 4 L Narsi	*	dence 6 Other (S	(pecify)	
fter ne	on:	27. Manner of Death 1 ☑ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	iry at irk?	28d. Describe	how injury occurred		
el or Attending s efter death. el Director: Afte	Certification;	2 Accident investigation 3 Suicide 6 Could not be				]Yes 2 □No				
or At fter d pirect n by	E	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		reet, factory, office		28f. Location ( City or To	Street and Number or wn, State)	Rural Route Number,	
To the Hospitel or At within 24 hours effer of To the Funerel Directompletely filled in by			1							
e Hospitel 24 hours e Funerel letely filled	cai	(Check only 2 Medical Exami	sician: To the best of my kiner: On the basis of examin	nowledge, deat nation and/or in	th occurred at the ti	ime, date and p opinion, death (	place, and due to the occurred at the time,	cause(s) and manner date and place, and	as stated. due to the cause(s)	
To the within 2 To the P	Medicai	one)	and manner stated.							
	-	29b. Signature and title of certifier	1 4 5 1 5	MX	29c. Licen	e umber	210	29d. Date signed (Me	onal, Day, Year)	
WIL		M) (C	wie	1.70	10-6	5054	210	04-15.	nonth, Day, Year)  -OS  -New MD 21159	
5		30. Name and ad re s of person who co			Print)	0. 1	0. 1	110.11	4 . 3 . 5	
3-2-1		DK. Kaman	13 Kane		49 Ma	colm	aure, l	NETTMIN	THEN MID	
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature /			ŕ		2113	

State of Maryland / Department of Health and Mental Hygiene Reg. No. 3. Time of Death Year

4:18 A

<sup>Day</sup> 2005

4c. County of Death

MONTGOMERY

Birthplace (State or Foreign Country)

1945 California

10d. Inside City Limits 1 Yes 2X No

10g. Citizen of What Country? United States

14. Race - American Indian, Black, White, etc. Specify: White

16b. Kind of Business/Industry

Telecommunications

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20c. Location - City or Town, State

Triangle, Virginia

| 4143 Dale Boulevard Dale City, Virginia

Approximate Interval Between Onset and Death

23d. Date of delivery Month

Year Day

1 Yes XX No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

APRIL 21 2005

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

LAWRENCE OSEI

31. Date filed (Month, Day, Year) APR 29

2005

DHMH 17 Rev 1/2001

State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 10 0 /Medical 4c. County of Death Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 1,5 om If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Number 6. Say 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 220-32 198€M 2□ F -873 MD Yrs. **Director** Usual Residence of Decedent with the Maryland 10a. State 10c City Town or Location 10d. Inside City Limits r than "neturel", or Items 23e or 28a-f show the Medical Exercites to ust be notified at 1 Yes 2 □ No MDFuneral Director rinces5 rom 6150 mne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21857 30868 Hampden filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify. Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Regional Medical Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fill and Mental H UNKnown Geraldine Kellam Pages 1 and 2 should treumetic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Easton or other tree Idaughter 608 August MD Diretta Harvis Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State crematory or other place) permit. Page Department o Importent: If any injury or once. John Wesley Cemelery 04-21-05 Prin Anthony B. Ward Funeral Hor 30639 Humpdun Ave. Princess 04-21-05 4 □ Donation 5 □ Other (Specify) Vincess 21. Signature of Funeral Service Licensee Home MD 21853 Ann ne re 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Dear Immediate Cause (Final disease or condition resulting in death) Matastatie **Physician** worth /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): burialphysician Box 68760 Physician/Medical the as attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9□ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe Yes. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 certificate 1 Yes No. Hospitel or Attending Physicien: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: Other: 1 mpatient 2 ER/Outpatient 3 DOA 2 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of eath 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à within 24 hours after To the Funerel Direct 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) To the I 29b. Signature and title of co 29d. Date signed (Month, Day, Year) if death (Item 23a) (T pe, Print) 30. Name and address of person who completed cause ONTAL DAND COUKLY MO 31. Date filed (Month, Day, Year) 32. Regis r's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day 2005 April 10, **Physician** Vivian H. Lambert 10:20 a<sup>M</sup> /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** Manor Care Potomac Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. 7, 9. Birthplece (State or Foreign Country) California 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1908 1 ☐ M 2 ☐ XF 119.14.1445 96 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or frame any injury or other traumation. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Montgomery Potomac Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10714 Potomac Tennis Lane 20854 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Nidowed 4 Divorced þ White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William J. Hall <u>Mathelda Arana</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene Lambert/ Son 5610 Wisconsin Avenue #1109 Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mt. Comfort Crematory 04/19/2005 | Alexandria, VA \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licensee 5130 Wisconsin Avenue NW WDC Varue 23a. Fert1. Enter the sea of the molications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** oronas 4 years /Medical Due to (or as a consequence of) Examiner Hypertension 5 years Dequentiarly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) the á been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an certificate has 1 Yes Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. investigation 1 Tes 2 No 2 Accident within 24 hours after death To the Funeral Diractor: the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital or 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Aborter D0053615 April 13, 2005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3800 Reservoir Rd., N.W. WDC Aruna S. Nathan, M.D. APR 1 8 2005 State

DHMH 17 Rev 1/2001

Registrar

amend item#18,20b, perfh, G843, 5/20b, Department of Health and Mental Hygiene, on the state of Maryland / Department of Health and Mental Hygiene, on the state of Maryland / Department of Health and Mental Hygiene, on the state of Maryland / Department of Health and Mental Hygiene, on the state of Maryland / Department of Health and Mental Hygiene, on the state of Maryland / Department of Health and Mental Hygiene, on the state of Maryland / Department of Health and Mental Hygiene, or the state of Maryland / Department of Health and Mental Hygiene, or the state of Maryland / Department of Health and Mental Hygiene, or the state of Maryland / Department of Health and Mental Hygiene, or the state of Maryland / Department of Health and Mental Hygiene, or the state of Maryland / Department of Health and Mental Hygiene, or the state of Maryland / Department of Health and Mental Hygiene, or the state of Maryland / Department of Health and Mental Hygiene, or the state of Maryland / Department of Health and Mental Hygiene, or the state of Maryland / Department of Health and Mental Hygiene, or the state of Maryland / Department of Health and Mental Hygiene, or the state of Maryland / Department of Health and Mental Hygiene, or the state of Maryland / Department of Health and Mental Hygiene, or the state of Maryland / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department / D 1- For Amend Item 1 per phy G844 6-7 Certificate of Death 1. Decedent's Name (First, Middle, Last) Rosa Aminta Larin 2. Date of Death 3. Time of Death **Physician** April 15 2005 9:36 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 69 Yrs. Months Days Hours Min. Feb 10 1936 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 1□ M XXF Ef°Salvador 212-63-1030 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X es 2 □ No Maryland Montgomery Germantown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19034 Grotto Lane 20874 El Salvador Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Yes 2□No Specify: Salvadorian þ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jose Santos Larin Carmen Velasquez-Campos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 19034 Grotto Lane Germantown, Maryland 20874 Elia Ramos (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other Pango Cementerio De Ylopango 4/23/05 20a. Method of Disposition

☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location · City or Town, State San Salvador, ElSalvador ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Maryland 20706 21. Signature Funeral Service Licenses luc Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a co Sequentially list conditions, it any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death by not regulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2**XX**10 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation М 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide TC Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check on one)

Division of Vital Records, P.O. Box 68760 al or Attending Physician: after death. I Director: After this certifica To the Hospital within 24 hours a To the Funeral C

**Funeral** 

Director

item 27 is marked other than "natural", or Itema 23a or 28e-f show other traumatic event, the Madical Examinar must be notified at

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once.

**Physician** 

/Medical

use as the burial-transit

ate has been signed by the attending physician and page 2 should be detached for use as the burial-trai

funeral

filled in by the

**Examiner** 

requires that the death certificate be executed

filed within 72 hours after death. Hygiene.

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State APR 1 8 2005 Registrar

29b. Signature a

d title of certifier



29c. License number

29d. Date signed (Month, Day, Year)

			Please	State of Ma		/ Depa	artment of	Health and			-	
			Registrar			Cer	tificate of	Death		Reg. No.	nno	
	Physicia /Medic		Decedent's Name (First, Middle, L     Raymond Alfon		Sr.				2. Date of De Month April	Day		3. Time of Death 6:17 PM
	Examin		4a. Facility Name (If not institution, g.	ive street and number)			4b. City, Town,	or Location of Dea	th	4c.	County of De	ath
			Holy Cross Hosp	ital			Silver			1	Montgor	
i	Funeral Director		100-24-2514	Sex 7. Age	72	t birthday) Yrs.	Months Days		(Month, Da	v. Year)	9. 8 1932 Ne	irthplace (State or Foreign Country) EW York
	pur .		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation					10d. Inside City Limits
	sho	5										1 X Yes 2 □ No
	the N	ect	D.C. N/A		wasn	ingto	10f. Zip Code	<del></del>		10a Citi	izen of What (	
	with	Funeral Director	1769 Sycamore St	reat NW			2001	2				
	leath	era	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. V			Specify Yes or No		ted Sta	nerican Indian,
_	r iter	Fun	1 ☐ Never Married 2X Married	1 XIYes 2 ☐ N	1954-			Hispanic Origin? ( ban, Mexican, Pue	nto Rican, etc.)		Black, Wh	
Š	ral', o	by	3 ☐Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1980		1⊡Yes 2∭∑No	Specify:		I.	Specify: Africar	n American
ה ה	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Cepariment of Heatth and Mental Hygiene. In portant: If Item 27 ia marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination in the ficilitied at the context of the first most of the fir	Completed	15. Decedent's (Specify only highest g	Education		16a. Deced	dent's Usual Occu	pation during most of we ed) Deputy	ndkina	16b. Ki	ind of Busines	
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2	be fill d oth	Be	17. Father's Name (First, Middle, Las	st)					ame (First, Middle		Sumame)	
2	Men Men arke	은	Louis Lambert						ia Halse			
9	2 sh and is m		19a. Informant's Name/Relationship					at and Number or F				
ב ע	and lealth m 27 her t		Gilda Lambert	(wife)	OOb Die			e St. N.V	V. Wash:			
5	ges it of h		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3				sition (Name of natory or other pl					or Town, State
allillor	t. Pa tmen tant:		'4 □ Donation 5 □ Other (Spec		Arli		n Nation		26/05		lingtor	
200	Derrill Departing In port		21. Signature of Funeral Service Lic	me Gui	40			ress of Facility Mo				
	40200		22a Part 1 Enter the disease or on	unplication of the coursed	the death						р. С.	20012 Approximate
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Coronar	y Art	ery I		, 119, 30011 d3 041010				Interval Between Onset and Death
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00/00	icate be physicia s the bur	cal	•	d		·						
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us, r.	uires that t signed by d be deta	þ	Part II. Other significant conditions	s contributing to death bu	ut not resulti	ing in the u	nderlying cause g	iven in Part I.	1			to the cause of death?
necords,	e law requ has been e 2 shoul	ompleted							24a. Was	DSV	prior to	autopsy findings available o completion of cause of
	cate	Col							perfe 1 Tes	2 X No	death'	es 2 No
VIII	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:			77 0	4	eath (Check only			
5	Phya this al dir	L	1 ☐ Yes 2 🛣 No 27. Manner of Death	I 🔲 Inpatie	nt 2□EF		IL SELDOA		Home 5 Res			pecify)
0	nding ath. r: After e funer	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injur (Month, Day ion	Year)	8b. Time of Injury	W	ury at ork? □Yes 2□No	28d. Describe	now injur	y occurred	
DIVISION	To the Hospital or Attending Phyaician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At hom c. (Specify)	e, farm, str	eet, factory, office	3	28f. Location ( City or To	Street an wn, State	d Number or i	Rural Route Number,
	he Hospi n 24 hour he Funer. pletely fill	Medical	29a. Certifier 1X Certifying 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examinatio	edge, death n and/or in	h occurred at the vestigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner I place, and d	as stated. ue to the cause(s)
	Tot	Σ	29b. Signature and title of certifier	11 7			29c. Licer	nse number		29d. Dat	te signed (Mo	nth, Day, Year)
	(3)		Varylette	1 dufle		Min	D 6	2175		,	31/13	(05
	+1		30. Name and address of person who Sangeeta Gupta					d, Silver	Spring	, MD	20910	)
Ì	Sta Registi		31. Date filed (Monaph Tar)		ar's Signati		raile			-		

DHMH 17 Rev 1/2001

			1 - For State Registrer	State of Marylan	-	artment of I			giene	5 11.000
	Physici /Medic Examir	al	Decedent's Name (First, Middle, Last     Tesfaye Assefa La     4a. Facility Name (If not institution, give	kew street and number)		4b. City, Town, o	or Location of De	2. Date of De Month April ath	Day Yea  14, 2005  4c. County of De	10:00 A M
	Funeral Director		5. Social Security Number 6. Se 602–84–7216 Usual Residence of Decedent		last birthday) Yrs.	Takon If Under 1 Year Months Days				nery irthplace (State or Foreign Country) Thiopia
	within 72 hours after death with the Maryland ene: then "natural", or itema 23a or 28a-1 show his Mikaleal Examinar must be rodified at	Director	10a. State 10b. County  Maryland Montgome  10e. Street and Number		, Town or Lo	r Spring			10g. Citizen of What (	10d. Inside City Limits 1 □ Yes 2 ▼ No Country?
5-0036	be filed within 72 hours after death with the Marylan lat Hygiene. Id other then "natural", or itema 23a or 28a-f show event, the Mudical Examinat must be rectified at	d by Funeral	8608 Leonard Driv 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	e. 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	ł	209] Was Decedent of H If Yes, specify Cub	Hispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	Specify:	nerican Indian, nite, etc.
7	d within 72 h jiene. ir then "natu ir e Nedicel	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation fe completed) College (1-4or 5+)	(Give life. I	dent's Usual Occup kind of work done DO NOT use retire Officer	during most of w	rorking	16b. Kind of Busines Military	,
Maryland 21	d 2 should be filed th and Mental Hygi 7 is marked other traumetic event, I	To Be C	17. Father's Name (First, Middle, Last)  Assefa Lakew 19a. Informant's Name/Relationship (T)	umo Print)			Abebe	ch Yol	Maiden Surname)  annes er, City or Town, State,	
	ges 1 and of Health if item 27 or other to		Fekre Tesfaye  20a. Method of Disposition  1 又 Burial 2 □ Cremation 3 只	Daughter 20b. P	801 I lace of Dispo	LONSWAY ( sition (Name of matory or other pla	Court	0 . 0	Tennessee 20c. Location - City of	37013
Baltimore,	permil. Pag Department Importent: any injury once.		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens	, 000	Park (	len Capit Cemetery Name and Addre Cancis J.	Apr ess of Facility Collin	s Funeral	Pflugervil Home, Inc. lver Sprin	•
>	Physician /Medical		23a. Part 1. Enter the disease, or composhock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)	ne cause on each line.  a. IOXIC Ma	Labo	er the mode of dyir	ng, such as cardi	acor respiratory as	rrest,	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence to consequence)	rscul	er a	ccide	nt.		
8760,	rate be executed obysiclen and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Laft Midd Due to (or as a consequence d. Athanocl	ionco of).	nbral Cardi	artey Diosci	occhi uler a	iscare.	
.O. Box 6	it the death certific by the attending p tached for use as t	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)	′		23d. Date of do Month	elivery Day Year
ords, P.	The law requires that the tee bas been signed by the base been signed by the bage 2 should be detache	by	Part II. Other significant conditions co.	l Failure			en in Part I.		obacco use contribute es 2 1210 3   F	to the cause of death?  Probably 4 □Unknown
Vital Record		Completed	TYPE IL Dia Malnutr	botes Med	li tus	7		1 ☐ Yes	prior to death?	
Division of Vit	ling Phys I. After this uneral dii	ertification: To Be	27. Mann of Death  1 Matural 5 Pending 2 Accident investigation		ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 Nursing		ne) lence 6 □Other (Sp low injury occurred	acify)
DIX	spital or nours afte neral Dir / filled in	edical Certific	Check only 2 Medical Exemi	28e. Place of Injury - At hos building, etc. (Specify sician: To the best of my knowner: On the basis of examinating	vledge, death	occurred at the tir	ne, date and plan	City or Tow	Cause(s) and manner a	s stated
	To ths Ho within 24 P To ths Fu completely	Medi	one)  29b. Signature and title of coefficient	and manner stated.		29c Licens	e number		29d Date signed (Mor	th Day Year
	Ġ Sta	te	30. Name and address of person who of 31. Date filed (Month Day, Year)	DR. ONEY  32. Segistrar's Signat	23a) (Type, I	Print) GA 4	701 RAN	dolph Rd.	Rockville	2005 Md. 20852
	Registr	_	APR 15 2	UUD Serene	U 19	And the second				

			1 - For State Registrar	State of Mary		artment of rtificate o		and Mental H	ygiene Reg. No.	nns	11000
I	Physici		Decedent's Name (First, Middle, Last)     Edward Bradley Le	ewis			.,	2. Date of I Month Apri	Death 1 12, 2	005 <sup>Year</sup>	2:30 A.M
	/Medic Examin		4a. Facility Name (If not institution, give str Renaissance Gardens @ Ri		age		n, or Location o	f Death	4c. Co	unty of Death	eorge's
	Funeral Director			7. Age (In	yrs. last birthday) 84 Yrs.	If Under 1 Ye Months Day		Min. 8. Date of E Aug. 30		9. Birthi	place (State or Foreign http:) yland
	e Maryland	ctor	Usual Residence of Decedent  10a. State  Maryland  10b. County  Montgomer	77.7	s. City, Town or Lo Silver S						10d. Inside City Limits 1 ☐ Yes 2√ No
	th with th	al Director	10e. Street and Number 3122 Gracefield Roa	ad,CT 614		10f. Zip Cod 20	。 0904			of What Cou ted Sta	
036	ours after dea al', or itama Examiner ma	by Funeral	11. Marital Status 12  1X Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify C		gin? (Specify Yes or ! , Puerto Rican, etc.)		Race - Americ Black, White, ecify:	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itama 23a or 28a-f show aumatic event, the Medical Evant sermante notified at	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5+) 5+	(Give	dent's Usual Oci kind of work do DO NOT use ret ter	ne during most	of working		of Business/In	
land	m = 0 S	To Be C	17. Father's Name (First, Middle, Last) Edward Daniel Let	wis			18. Mother Sara	r's Name <i>(First, Midd</i> h	lle, Maiden Sur		radley
	nd 2 shou alth and M 27 is mai		19a. Informant's Name/Relationship (Type Daniel Abbott –frier	, Print) nd	19b. Mailir 1547	ng Address (Stree Modoc I	eet and Numbe Avenue	r or Rural Route Num Norfolk, V	nber, City or To Virginia	wn, State, Zip a 2350	Code) 03
altimore,	Pages 1 a ent of Hes nt: ff itam ry or otha		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	Ob. Place of Dispo cemetery, crei	sition (Name of matory or other p itan Cre	olace) ematory	Date 4/13/2005		on-City or To	
Balti	permit. Pages 1 and 2 should by Oppartment of Health and Menta important: if item 27 is marked any injury or other traumatic and ODG.		21. Signature of Funeral Service Licensee	3 manual	i d	onaia d'	dress of Eacility	ardt Funer	al Home	PA	yland 20705
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)		death. Do not ent	er the mode of o	dying, such as				Approximate Interval Between Onset and Death 2 months
8760,	icate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uissase or injury that initiated events resulting in death) Last	Due to (or as a cor							
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	. If yes, outcome of pr 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3 [	Ectopic pregna Other (specify)			23d.	Date of delive Month	ery Day Year
ds, P	puires that n signed h		Part II. Other significant conditions contri	buting to death but no	t resulting in the u	nderlying cause	given in Part I.		d tobacco use d ∐Yes 2 <b>X</b> ∏Ne		ne cause of death?
Vital Records,	ilcian: The law requir certificate has been si rector, page 2 should	e Completed	25. Was case referred to medical				OC Disease	24a. We aui pei 1 ☐ Yes	topsy rformed? 2⊠No	tb. Were auto prior to co- death? 1 \(\sum \) Yes	psy findings available mpletion of cause of
Division of Vi	Phys this aldii	ertification; To B	examiner?	spital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury	28c. Ir	Othor	sing Home 5 🗀 Re 28d. Describ			y)
Divis	al or Atta s after de al Directo ed in by th	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, str oecify)	eet, factory, office	се	28f. Location City or 7	(Street and Nu own, State)	mber or Rura	l Route Number,
	To the Hospital or Attanding within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) Certifying Physic 2 Medical Examine	ian: To the best of my r: On the basis of exa- and manner stated.	/ knowledge, death mination and/or in	occurred at the vestigation, in m	time, date and y opinion, deat	d place, and due to the h occurred at the time	e cause(s) and e, date and plac	I manner as si ce, and due to	tated. the cause(s)
}	To t To t	Σ	29b. Signature and title of certifier Pur	human	a, MD	29c. Lice D5	ense number 9524			gned (Month, L 13, 2	
	20		30. Name and address of person who com Loveen Puthumana, if	nleted cause of death	(Itam 23a) /Tuno	Print\	Silver	Spring, M	Maryland	20904	1
	Sta Registi	1	31. Date filed (Month PR 15 200	32. Jegistrar's S		arle					-

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 1Day Physician 2005 1:07 AM Rocco Mazzone /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Howard Ellicott City 3100 N. Ridge Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Min. | May 1, 1909 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F England 95 Yrs 061 03 1898 Director Usual Residence of Deceden the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director Ellicott City MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21043 United States 3100 N. Ridge Road death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. And it item 27 is marked other then "natural", or lite, any or other traumatic event, ITE Medical Exactionary or other traumatic event, ITE Medical Exactionary 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Yes, Give Specify: Completed by 3 XWidowed 4 ☐ Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Butcher Shop unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emidio Mazzone Congetta Papa 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3702 Takoya Drive Ellicott City, MD 21042 Ronald J. Mazzone/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State Oak Ridge Cemetery 4-18-2005 Inverness, FL \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee △M01044 0 4112 Old Columbia Pike Ellicott City, MD 21043 hem Umo 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final anthorostensis 50 **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ubstructue lung cliseese. 11 runic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) HOWAN OF JUST A 48. Box 68760, Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed ð hnossvo 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2**%**] No 1 Yes 2 XNo 1 Yes 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) asst. livg P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 XNatural death. 1 ☐Yes 2 ☐ No 2 Accident 4 hours after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funarai C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D56651 MO April 11, 2005 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Drive -11665 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 8 2005 Registrar

			1 - For State Registrar	State of N	Naryland / Dep <i>Ce</i>	artment of F			iene	15 14689	
	Dhariai	é	1. Decedent's Name (First, Middle, Last	)				2. Date of Deat	h	3. Time of Death	
	Physici /Medio		Joseph Al	oysius M	addox, Sr.			April 20		5:00 A M	
	Examin		4a. Facility Name (If not institution, give	street and numbe	r)	4b. City, Town, o	r Location of D	eath	4c. County of	Death	
		*	Genesis Eldercare			La Plat			Char1e	es	
	Funeral Director		5. Social Security Number 6. Se 15	X 7.7 7M 2□F	Age (In yrs. last birthday 62 Yrs.	Months Days	If Under 24 Hours	Hrs. 8. Date of Birth (Month, Day, April 30,	Year)	9. Birthplace (State or Foreign Country) Maryland	
			Usual Residence of Decedent					April 30,	1772	riai y land	
	yland		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits	
	Ma Ma	cto	Maryland Saint Mar	/¹s	Leonardtow	n				1 ☐ Yes 2 No	
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	nat Country?	
	23e	rail	28460 Point Lookout I	Road		20650			USA		
	tems	Funerai	11. Marital Status	<ol><li>Was Deceder Armed Forces</li></ol>	s?	Was Decedent of H If Yes, specify Cuba	ispanic Origin an, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		- American Indian, White, etc.	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □ Yes 2 5 If Yes, Give Year or Dates	•	1□Yes 2∏ No	Specify:		Specify:		
8	hour	ed t	15. Decedent's Edu			ident's Usual Occup	ation		16b. Kind of Busi		
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show fre Medical Ever in er mart te rediffical at	Completed	(Specify only highest grad	le completed)	(Give	kind of work done of DO NOT use retired	during most of	working	iod. Italia of Dagi	no samudatry	
212	d with giene. ir ther	mo;	12	College (1-4o	· ·	ick Layer			Construct	tion	
	be filed ital Hygis of other event, t	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle, M	faiden Sumame)		
yla	should bind Ment marked umatic e	2	Harold Joseph Maddox				Mary E	leanor Carter			
Maryland	2 sho		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mail	ing Address (Street	and Number o	r Rural Route Number,	City or Town, St	tate, Zip Code)	
	of Health of Health item 27 i		Mary Katina Maddox / I	aughter	P.O.		onardtown	n, Maryland 2			
Baltimore,	perrit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23s or 28e-f show any injury or other treumatic event, the Medical Exercities in and be reclifted at ance.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F		domotons are	matory or other plac	(8)	April	20c. Location - Ci	ity or Town, State	
計	t. Pa rtmer rtent rtent njury		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral → ice □ icens</li> </ul>			norial Garde		25, 2005 L	eonardtown	n, Maryland	
Ba	perrit. Pages Department of the Importent: If ite any injury or of once.		21. Signature of Puneral Time Elicens	» ~	M	2. Name and Address attingley-Ga .O. Box 270	ardiner 1	Funeral Home, dtown, Maryla	P.A. nd 20650		
,8760,	Physician /Medical Examiner but sician and proving Italian ithe prival Italian ithe prival Italian ithe prival Italian ithe prival Italian ithe prival Italian ithe prival Italian ithe prival Italian ithe prival Italian it	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
.O. Box 6	the death certifi y the attending I iched for use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other ( <i>specify</i> )			23d. Date of Month	*	
rds, P	sign d be	ed by P	Part II. Other significant conditions co	ntributing to death	but not resulting in the u	inderlying cause give	en in Part I.			ute to the cause of death?	
Records,	The law requate has been bage 2 should	Completed	- · ·					24a. Was an autopsy perform	ed? pric	ore autopsy findings available or to completion of cause of ath?  Yes 2 \sum No	
Vital	yeicien: The is certificate hadirector, page	BeC	25. Was case referred to medical examiner?				26. Place of	Death (Check only one	T		
of V	Physicien: this certific ral director,	P	1 ☐ Yes 2 KNo	lospital: 1 ☐ Inpa			4 yoursin	g Home 5 ☐ Resider	nce 6 Other	(Specify)	
		ion:	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Time o Pay Year) Injury	Work	</td <td>28d. Describe how</td> <td>w injury occurred</td> <td></td>	28d. Describe how	w injury occurred		
Division		ertification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I building,	njury - At home, farm, st etc. (Specify)		Yes 2□No	28f. Location (Str. City or Town,	eet and Number State)	or Rural Route Number,	
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	0	29a. Certifier Certifying Phy (Check only 2 Medical Exam)	sician: To the bes	of my knowledge, deal	h occurred at the tim	ne, date and pl	ace, and due to the cal	use(s) and mann	er as stated.	
	To the H within 24 To the Fi complete	Medical	29b. Signature and title of certifier	and manner	of examination and/or instated.	29c. License				Month, Qay, Year)	
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	Sta Registr		31. Date tiled (Month, Day, Year) APR 2 2 2	005 32. Sis	trar's Signature	back		-		/	

		1. Decedent's Name (First, Middle,	Last)	Marylan II per						<ol><li>Date of De Month</li></ol>	ath Day		Year	3. Time o	Death
Physici /Media			Rosalie	Mar	cquis					April	13,		005	18:50	)
Examir		4a. Facility Name (If not institution,	•	er)		4b. City, To			Death		4c. C	ounty o	of Death		
		University Hosp		A == //=	In a 4 to bath of a 13		1timo		4 Uro	0.0					
Funeral Director		5. Social Security Number 006-36-6334	5. Sex 7. 1 ☐ M 2 🖾 F	66	last birthday) Yrs.			lours	Min.	8. Date of Bir (Month, Da April	y, Year)	39	9. Birthp	place (State on try) Mai	or Fore
Jirector		Usual Residence of Decedent									-,				
how		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							1	0d. Inside C	ity Lin
B-F 8	ctol	Maryland Ce	cil				Perr	yvi	lle					1 🗆 Yes	2 🔀
or 28	Director	10e. Street and Number				10f. Zip Co					10g. Citize			ntry?	
8 23a		824 Jackson St			1			1903			1		S.A.		
Item	Funeral	11. Marital Status	12. Was Decede Armed Force od 1 ☐ Yes 2	es?	.S. 13.	Was Deceden If Yes, specify	t of Hispar Cuban, M	nic Origi Iexican,	in? (Spe Puerto	ecify Yes or No Rican, etc.)	)- 14		- Americ , White,	ean Indian, etc.	
0	by F	1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Give Year or Date			1 □ Yes 2 🗷	No S	pecify:			s	pecify:		White	
atura	ted	15. Decedent's	Education		16a. Dece	dent's Usual C	Decupation	1			16b. Kind	of Bus	siness/Inc	dustry	
M P	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4	or 5+)	(Give	kind of work of DO NOT use i	done durin retired)	ng most (	of worki	ng				,	
giene er the	Com	Eleven Years	January Communication Communic			Homer	maker				Pers	sona	al Re	esiden	се
d oth	Be (	17. Father's Name (First, Middle, La	ast)				18.	Mother	's Name	(First, Middle,	, Maiden Si	umame	)		
Men arke	인		ce E. Dup	uis						ry Lou					
it of Health and Mental Hygiene. If item 27 is marked other than "naturat", or items 23a or 28a-f show or other traumatic event, the Medical Exercites must be nutilled at		19a. Informant's Name/Relationshi Wilfred A. Maro			1					ad, Per				Code) 2190	3
lealth im 27 her ti				20h E		osition (Name		LIOI		ad, re					ა —
it of H		20a. Method of Disposition 1 Burial 2 □ Cremation 3		ate	cemetery, crei	matory`or othe	er place)	-						wn, State	
rtmen rtant: rjury		`4 □Donation 5 □ Other (Spe		St		's Ceme				.9/05	Perry	yv11	LIE,	Maryl	an
Important: If item 27 is any injury or other tra		21. Signature of Funeral Service Li	Censee	/-		2. Name and A $ee A$ . ]				Son Fur	neral	Ноп	ne, I	P.A.	
		Morriedit	MERCALL												
ysician Medical		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a Atheims	clero	th. Do not ent tic car	ter the mode o rdiovas	of dying, su scula:	uch as ca r di	ylan ardiac o i <b>sea:</b>	d 2190 or respiratory a Se	03-076 rrest,	56		Approximat Interval Bet Onset and	wee
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		1 - For State Registrar	State of Maryland	-	artment of I			ene	A Auto
Physic /Medi			YER				2. Date of Death Month April	Day 20	3. Time of Death
Exami Funeral	ner	4a. Facility Name (If not institution, gives  Heart Homes Assis  5. Social Security Number 6. Sex	ted Living	st birthday)	Odento:			Anne An	runde1
Director		Usual Residence of Decedent	JM 2₹ 92	Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Day, Feb. 17,	1913	9. Birthplace (State or Foreign Country) Ohio
the Maryla 28a-f shov	rector	MD Anne Arun  10e. Street and Number		nton	10f. Zip Code		10	g. Citizen of Wr	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
sath with s 23a or	Funeral Director	8735 Piney Orchar			2	1113		USA	<u> </u>
Dallillore, Mary Jiding Z. I.Z. 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show may injury or other traumatic event. The Medical Evaning must be notified at ance.	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	ĺ	Was Decedent of F f Yes, specify Cub	Hispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- into Rican, etc.)		- American Indian, White, etc. White
within 72 h within 72 h ene. than "natu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give life. l	lent's Usual Occup kind of work done DO NOT use retire t Grade	during most of w d)	orking	6b. Kind of Bus	,
Tal ylallu KIKI 2 should be filed within and Mental Hygiene Is marked other than aumatic event, Ins Ma	To Be Co	17. Father's Name (First, Middle, Last)  John Burkam	U	FILS	c Grade	18. Mother's N	ame (First, Middle, M		
i, INICIT YIC and 2 should ealth and Men n 27 Is marke ier traumatic		19a. Informant's Name/Relationship (Ty Ray Meyer - Son		3483	Constell	and Number or F	Rural Route Number,		rate, Zip Code)  MD 21035
Dallillore  bermit. Pages 1 Department of H mportant: If iter iny injury or oth		20a. Method of Disposition 1 ⅓ Burial 2 ☐ Cremation 3 ☒ R  `4 ☐ Dog/ation /5 ☐ Other (Specify)	/ Tru:	ace of Dispo metery, cren ro Cen	sition <i>(Name of</i> natory or other pla letery	<sub>сө)</sub> 5/1	Date 2	oc. Location - C	ity or Town, State  Grove, Ohio
permit. Departr Importe any inji	L	21. Signarure of Funeral Service Liches	u/	4	739 Balt	imore Av		tsville	ne, P.A. z, Maryland
Physician /Medical Examiner		23a. 'an' En in thi disease, or complished shots or heart failure. List my Immediat Cause (Final disease in condition resulting in death)	ations that caused the death. e cause on each line.  Tan Ture  Due to (or as a consequ	o Th		ng, such as cardi	ac or respiratory arre:	st,	Approximate Interval Between Onset and Death
icate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)						
The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  O	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of decentions	death 3	Ectopic pregnanc Other (specify)	y .		23d. Date Monti	
w requires that been signed t	by P	Part II. Other significant conditions cor	tributing to death but not resul	Iting in the ur	nderlying cause giv	ren in Part I.	23e. Did toba	1-0	ute to the cause of death?
	Completed						24a. Was an autopsy perform 1 \( \text{Yes} \) 2	ed? pri	ere autopsy findings available or to completion of cause of ath? ] Yes 2 [] No
ysiciar ysiciar is certif director	o Be	25. Was case referred to medical examiner?	lospital: 1   Inpatient 2   E	R/Outpatien	t 3 DOA Ott	The same of the sa	eath (Check only one Home 5 - Resider		(Specify)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ertification: T	27. Manner of D ath  1 Natural 5 Pending investigation		28b. Time of Injury	28c. Injur	v at	28d. Describe how		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the the	0	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)				City or Town,	State)	or Rural Route Number,
To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier 1X Certifying Physics (Copeck only one) 2 Medical Ekaming one)	cian: To the best of my know er: On the basis of examinati and manner stated.	rledge, death on and/or inv	occurred at the til restigation, in my o	me, date and place printon, death occ	e, and due to the cau	ise(s) and manr e and place, an	er as stated. d due to the cause(s)
To t withi To t	M	29b. Signature and title of certifier	John		29c. Licens	e number 058166		d. Date signed (	Month, Day, Year)
		30. Name and address of person who co Eric Marcalus MD.				#101, E	Edgewater,	Marylan	nd 21037
St	ate rar	APR 1 8 2005	32. Registrar's Signatu						

			For State Registrar	State of Ma	aryland / Dep	artme	ent of Health and ate of Death	Mental Hy	/giene	2005	1469
g.	Physici /Media		Decedent's Name (First, Middle, Last     Leroy Lee Matthey	vs		45 0	T	2. Date of D. Month April	15,	2005	3. Time of Death 7:30 A.M.
	Examir	er	4a. Facility Name (If not institution, give Prince George's I		enter	46. Ci	ty, Town, or Location of Deat Cheverly	n		c. County of Death	orge!s
6	Funeral Director		5. Social Security Number 6. S 579–30–8625	-	6 (In yrs. last birthday) 6 Yrs.	If Und Month	der 1 Year   If Under 24 Hrs		irth	Q Riethe	place (State or Foreign ntry)
	the Maryland 28a-f show notified at	ector	Usual Residence of Decedent  10a. State 10b. County  Md P.G.  10a. Street and Number		10c. City, Town or Lo	nsbu	rg Zip Code		100 Ci	itizen of Whal Cou	10d. Inside City Limits 1 ✓ Yes 2 □ No
	with Ba or	ā	5999 Emerson St.	# 919		101.	20710		10g. O	U.S.A.	iniy:
036	be filed within 72 hours after death with the Maryland nat hygiene.  d other than "natural", or items 23a or 28a-f ahow other than "natural", or items 23a or 28a-f ahow event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ H If Yes, Give Year or Dates:	Ever in U.S. 13.		cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer 2 No Specify:	Specify Yes or N to Rican, etc.)	0-	14. Race - Ameri Black, White,	
21215-0036	within 72 ho ane. Ihan "natur se Medical I	Completed	15. Decedent's Ec (Specify only highest gra		(Give life.	kind of DO NOT	sual Occupation work done during most of wo Tuse retired)			Kind of Business/In	dustry
م 2	a filed Il Hygid other	Be Co	12th 17. Father's Name (First, Middle, Last)		Off	set_	Press Printer 18. Mother's Na			inting n <i>Sum</i> ame)	
ylar	ould be Mental arked o	ToE	Unknown					knewn			
Maryland	d 2 shu th and 7 Is m traum		19a. Informant's Name/Relationship ( Lillie Mae Matthew			•	ess (Street and Number or Ri rson St.# 919				,
	f Heali fem 2 other		20a. Method of Disposition		20b. Place of Disposemetery, cre			Date		ocation - City or To	
Baltimore,	permit. Peges 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic a <u>once</u> .		1 🙀 Burial 2 □ Cremation 3 □  `4 □ Donation 5 □ Other (Specify				'l. Mem. Pk.	4/22/05	Laur	rel. Md.	
3alti	permit. Departn Imports any Inju		21. Signature of Funeral Service Licer	See C	2	2 Name	and Address of Facility Washington & Burroughs Av	Sons Co.	. Inc	· 2.	
5	Physician /Medical Examiner	Examiner	23a. Part1. Exter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Obsease or injury	a. NTRACK Due to (or as	I the death. Do not enter.  ANIAL Hard a consequence of):	ter the m	ode of dying, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
68760,	tificate be executed g physicien and as the burial-transit	a	that initiated events resulting in death) Last	Due to (or as	a consequence of):						
P.O. Box	that the death certificate I ed by the attending physi detached for use as the b	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnan! at 9 ☐ Unknown	2 Fetal death 3		pregnancy (specify)			23d. Date of delive Month	ery Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	ınderlyin	g cause given in Part I.		tobacco Yes 2		he cause of death? pably 4 Unknown
Division of Vital Records,	The ate h page	Completed						24a. Waa auto perf 1 □ Yes		prior to co death?	opsy findings available impletion of cause of 2 No
Vit	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2 ER/Outpatie		Other	ath (Check only		4 Flori 40	
on of	Jing After fune	ition: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry 28b. Time o		28c. Injury at Work? 1 Yes 2 No	28d. Describe		6 ☐Other (Specifing occurred	y)
Divis	To the Hospitei or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - Al home, farm, st c. (Specify)	reet, fact	ory, office	28f. Location City or To	(Street at own, State	nd Number or Rura e)	al Route Number,
	the Hospitei or hin 24 hours atte the Funeral Dir npletely filled in	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Madical Exam	ysician: To the best ninar: On the basis of and manner st	f examination and/or in	th occurr ivestigati	ed at the time, date and place on, in my opinion, death occu	e, and due to the urred at the time	cause(s , date an	s) and manner as s d place, and due to	tated. o the cause(s)
	To the Comp	Š	29b. Signature and title of certifier	)-/.			29c. License number			ate signed (Month,	
,		1	1 / chael	Light		D.: ::	D52865		)	+-15-1	15
K	15)			completed cause of d	Jeath (Item 23a) (Type 3 to 1 H)	Print)	AL DR	CHEVE	RLY,	H-15-1	785
	St: Regist	ate rar	31. Date filed (Month, Day, Year)  APR 1 8 200	5 Albus	A A	We !	*****				

		1 - For Registrar		Maryland /	Depa		t of H	ealth a		ental Hy		905 005	14693
Physic	ian	1. Decedent's Name (First, Middle	a, Last)	=11-211						2. Date of De		Year	3. Time of Death
/Medi		LINDA		EHOU.	JE				ć	24	15	05	400 AM
Exami	ner	4a. Facility Name (If not institution		oer)				Location of	f Death			unty of Death	
Funeral		12901 Beechtr 5. Social Security Number		Age (In yrs. last b	irthday)	If Under	wie 1 Year	If Under 2	24 Hrs.	8. Date of Birt		nce Ge	
Director		089-40-5713 Usual Residence of Decedent	1□M 2 <b>E</b> F	53	Yrs.	Months	Days	Hours		Jan. 27	, Year) 195	2 New	place (State or Foreign http:// York
yland		10a. State 10b. County		10c. City, Tox	wn or Lo	ocation						Ţ.	I0d. Inside City Limits
death with the Maryland ms 23a or 28a-f ehow rmust be notified at	ctor	Md. Prin	ce Georges		Во	wie							1 X Yes 2 ☐ No
ith th	Director	10e. Street and Number				10f. Zip						of What Coul	ntry?
s 23a	rai	12901 Beechtr						715				USA	
after or its	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force ied 1 ☐ Yes 2 If Yes, Give- Year or Date	es? ∑ <b>X</b> No		Was Deced If Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican, Specify:	in? (Spec Puerto R	city Yes or No- lican, etc.)		Race - Americ Black, White, ecify: Whi	etc.
3-UU36 72 hours af "natural", or	Completed	15. Deceden (Specify only higher	t's Education	168	a. Dece	dent's Usua	l Occupa	ition	ad wandiin	_	16b. Kind o	of Business/In	dustry
ithin Med	d d	Elementary/Secondary (0-12)	College (1-4			kind of wor DO NOT us	e retired)	uring most	or working	g			
Hygier ther th		17. Father's Name (First, Middle,	9+		Teac	cher		40.14.4				cation	
d be til ntai H	Be		casi) ginald Will	iam Swin	vare	1		18. Mother		(First, Middle, Grube		name)	
Me Me	5	19a, Informant's Name/Relations					(Street a	nd Number		Route Numbe		um Stato Zio	Codo
re, Mar s 1 and 2 sh f Health and item 27 ie m other treum		James F. Morel								Bowie,			
of Hear	-	20a. Method of Disposition		20b. Place					4-22-			on - City or To	
alfilmo		1  Burial 2  Cremation  1  Other (S		Kinder							Colum:	bia, Ne	ew York
Dall permit. Depart Import any nji		21. Signature of Funeral Service	Licensee	11		2. Name and				all Fun			
1 005 g a		Ja Jan	I Wise	4	1	6512 N	V.W.	Crain	n Hwy	., Bow	ie, Ma	aryland	1 20715
Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on eac	n line.									Approximate Interval Between Onset and Death
Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequence	of):	ans	ler	ta;	ho	w			6 414.
orou, ate be executed hysicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		diopas as a con quence			Per	lme	7	1 1	is	0-26	,
XX 06/0U, certificate be executed rding physicien and ise as the burial-transit	edical E		d										
death death e atter	hysiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		n 2 ☐ Fetal death t at time of death		Ectopic pre Other (spe					23d.	Date of delive Month	ory Day Year
ecords, F.O. law requires that the es been signed by th 2 should be detache	by P	Part II. Other significant condition	ns contributing to deat	_		nderlying ca					bacco use o		e cause of death?
w requires been sign	leted			1	0				_				, , , , , , , , , , , , , , , , , , , ,
The The ate h	e Compl	25. Was case referred to medical	-							24a. Was a autop: perfor	med? 2 M No		osy findings available inpletion of cause of 2 No
Or VICA Physician: this certific ral director,	0	examiner?	Hospital:	atient 2 ER/O	utoatien	t 3 DO	Other			Check only or 9 5 Resid		Other (Specifi	41
Attsnding Phys attending Phys or death. ector: After this by the funeral din	ation; T	27. Manner of Death  1 Natural 5 Pendin 2 Accident investig	28a. Date of I (Month,		Time of Injury		lc. injury Work	at ? es 2 □ Ne	28	d. Describe h			9
oi or Atts s after de ni Directo	Certification:	3 Suicide 6 Could r 4 Homicide determ	ned 286. Place of	Injury - At home, fa	arm, str	eet, factory,	office		28	If. Location (S City or Town		ımber or Rura	l Route Number,
To the Hospitei or Attending I within 24 hours after death. To the Funeral Director: Atter completely tilled in by the funer	edical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the be Examiner: On the basi and manner	s or examination ar	e, death	occurred a vestigation, i	t the time	e, date and inion, death	place, an	d due to the c d at the time, o	ause(s) and late and plac	manner as sto ce, and due to	ated. the cause(s)
To the Vithin To the Comp	Σ	29b. Signature and title of certified	1	7		29c.	License	number	1,	2	9d. Date sig	gned (Month, I	Day, Year)
1		1. S. all				0	101	232	10	1	Sth	Apri	1,2005
140)		30. Name and address of person				Print)							
Sta	ate	Shahzad Ahmad 31. Date filed (Month, Day, Year)	MD, 3300 G	allows Ro	۵.,	ralls	Chu	rch,	VA 2:	2042-33	300		
Regist		APR 1 8	2005	istrar's Signature	1/20	Me of							

			1 - For State Registrar	State of	Marylan		artmen rtificat			and M	lental H	ygiene Reg. No.	200	5	14694
	Dhysisi	22	1. Decedent's Name (First, Middle, Las	st)							2. Date of D	eath Day	`	/ear	3. Time of Death
	Physici /Medic		GENEVA M	IcCARGO							4	13	5 0	5	2:40 A.M
	Examin	er	4a. Facility Name (If not institution, give	street and numb	er)				Location o	of Death	'		County of		
			Cresent Cities Nu					erda.		0711-					orge's
п	Funeral		5. Social Security Number 6. S	ex □M 21∑F /.	Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under a	Min.		av, Year)	1.5	9. Birthp	place (State or Foreign
	Director		409-18-8657 Usual Residence of Decedent		89						Aug. 1	5, 19	15	Атаг	oama
	land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	0d. Inside City Limits
	Mary f sh	ğ	MD Prince 0	lenroe's	Oxor	n Hill									1X Yes 2 No
	r 28e	Director	10e. Street and Number	corge o	001		10f. Zip	Code				10g. Citi	zen of Wh	at Cour	ntry?
	h with		2103 Norlinda Ave	nue				2074	5			B1a	ıck		
	ours after death with the Marylan ral', or Items 23a or 28e-f show Exprimer mast be motified at	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.	.S. 13.	Was Deced	dent of Hi	spanic Orig	gin? (Spe	ecify Yes or N Rican, etc.)		14. Race -		can Indian,
9	or Ite		1 ☐ Never Married 2 ☐ Married	Armed Force	X No	l l	rres,speo 1⊡Yes :			, Puerto	Hican, etc.)			White,	etc.
8	72 hours after death with the Maryland netural', or Items 23s or 28e-f show diest Exacting mast be matified at	b 5	3 Widowed 4 □ Divorced	If Yes, Give Year or Date	98:		10165	223 140	эрөспу.				Specify:	Blac	:k
Ϋ́	72 ho	Completed by	15. Decedent's Ed (Specify only highest gra	ducation de completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	al Occupa rk done d	ition Juring most	of work	in <i>g</i>	16b. Kii	nd of Busi	ness/In	dustry
121	within ene. then *	ם	Elementary/Secondary (0-12)	College (1-4	or 5+)										
2	be filed withital Hygiene. Id other then		17. Father's Name (First, Middle, Last)			Dome	estic	wor	_	do Nome	e (First, Middl		ivat		
anc		Be										e, maruen	Jumame)		
Ē	should ind Men marke umatic	ဥ	Jim Kelly  19a. Informant's Name/Relationship (	Type Print)		10h Mailir	a Address	/Street a			Beck al Route Num	har City	Tour St	nto Zin	Cada
Maryland 21215-0036	C1 (0 = 0		Lebron M. McCargo	_			-				Oxon H				,
	1 and Health Iem 27		20a. Method of Disposition	, bon	20b. P	lace of Dispo	sition (Nan	ne of	-		Date	,			own, State
Baltimore,	0 0		1 X Burial 2 ☐ Cremation 3 X 4 ☐ Donation 5 ☐ Other (Specification)		ate	emetery, crer	-			/ /20	/2005				
Ħ			21. Signature of Funeral Service Licer		FO	rest H					ch's F				sachusetts D A
Ba	permit. Departr Importe any inji		1/1/- /	K M	1127	_									aryland
			23a. Part1. Enter the disease, or com	plications that cau	sed the death								71110	, 110	Approximate
	Dhysisian		shock, or heart failure. List only Immediate Cause (Final	one cause on eac	h line.		0 4	la	^ ^	2	1-9 0	0 0			Interval Between Onset and Death
1	Physician / /Medical		disease or condition resulting in death)	a. Due to (or	as a conseq	uence of\\	000	,	7		02	77	۷	-	
н	Examiner			14	CHI	tra	on	5	71	~					
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	b. Due to (or	as a conseq	uence of):							<del>-</del>		
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	C											
ó	an an rial-tr	EX	resulting in death) Last	Due to (or	as a conseq	uence of);									
8760,	cate be executed bhysician and the burial-transit	dlcal		d											
9	ng ph	Jed	IF FEMALE:										-		
Вох	death certific e attending p od for use as	an/I	23b. Was decedent pregnant	23c. If yes, outco	me of pregna h 2 ∐Fete		Ectopic pr	egnancy				2	3d. Date		
	0 0	sicl	in the past 12 months?	4□Pregnar 9□Unknow	at at time of d		Other (sp						Month	1	Day Year
P.0	at the de	Physiclan/Me	9 Unknowń												
Ś	The law requires that the tite has been signed by thoage 2 should be detache	þ	Part II. Other significant conditions of	ontributing to dear	th but not res	ulting in the u	nderlying c	ause give	in in Part I.						ne cause of death?
ord	w requir been s should	ted									1	Yes 2	_ No 3	Prob	ably 4 MUnknown
e C	law re nas be	ρle									24a. Wa aut	opsy	pric	or to cor	psy findings available mpletion of cause of
Vital Record		Completed									per 1 ☐ Yes	formed? 2DNo		ath? ] Yes	2 No
/ita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?							of Death	(Check only	one)			
of \	his I di	ဥ	1 ☐ Yes 2 No	Hospital: 1 ☐ Inp		ER/Outpatier			4 200		me 5□Res				y)
	ing P	0.:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		8c. Injury Work			28d. Describe	how injury	occurred	i	
sio	Attending ir death. ector: After by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				М		res 2 🗆						
Division	iel or Attending Pisatler death.  I Director: After tiel in by the funera	Certification;	4 Homicide determined	28e. Place of	Injury - At ho , etc. <i>(Specif</i> )	ome, tarm, str y)	eet, factory	, office				(Street and own, State)		or Rura	l Route Number,
_	Hospitel or Att 24 hours after d Funerel Direct tely filled in by 1		29a. Certifier 1 Certifying Ph	veicion: To the h	act of my kno	uniodeo destin		-4 45- 41-		d = la = a					
	10 10	Medical	(Check only 2 Medical Exen	niner: On the bas and manne	is of examina	tion and/or in	vestigation,	, in my op	inion, deat	th occurr	ed at the time	, date and	place, and	d due to	the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier				290	. License	number			29d. Date	e signed (	Month,	Day, Year)
	->-0						1	111	207			U	113	21 1	71
0	(IL)		30. Name and address of person who	completed cause	of death (Item	n 23a) (Type	Print)	70	X C ~	10	00 8		111	101	· J
1	5		HHOY QUEE	ne son	m 2	Day	1	Lui	end	ahe	. in	12	077	37	1
	Sta	ite	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa	iture _	<u> </u>	, -00		~~ `	-				
	Regist	ar	APR 1 5 2005	Block	J 18.	Andre									

			1- State of Maryland / Dep	partment of Health and Mertificate of Death	Mental Hygi	•	14695
	Physici	an	1. Decedent's Name <i>(First, Middle, Last)</i> <b>James Madison Myrick, Jr.</b>		2. Date of Death Month	Day 2005	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 8518 60th Place	4b. City, Town, or Location of Death Berwyn Heights	April	13, 2005  4c. County of Deat Prince G	h
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 214–30–0825 1 № 2 □ F 72 Yrs.		8. Date of Birth Month, Day, June29,		hplace (State or Foreign untry)  1ana
	Maryland a-f show filed at	tor	Usual Residence of Decedent  10a. State   Maryland   Prince George's   10c. City, Town or Berwyn	Location Heights			10d. Inside City Limits 1 ▼Yes 2 □ No
	h with the 23a or 28u st be not	Funeral Director	10e. Street and Number 8518 60th Place	10f. Zip Code 20740	1	g. Citizen of What Co Jnited Sta	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel" or Itams 23a or 28a-1 show emportent: If item 27 is marked other than "neturel" or Itams 23a or 28a-1 show emportent: If item 27 is marked other than "marked by any or other traumatic event, the Medical Evant at most be purified at ODGE.	by	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married In Wes 2 No If Yes, Give Year or Dates: Korea	3. Was Decedent of Hispanic Origin? (State of Yes, specify Cuban, Mexican, Puerton of University of Specify:  1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	nican Indian, a, etc. hite
Maryland 21215-0036	thin 72 ho e. an "netur Medical	Completed	(Specify only highest grade completed)  (Gillege (1-4or 5+)	edent's Usual Occupation re kind of work done during most of work . DO NOT use retired)	ring	6b. Kind of Business/	
2	Hygien Hygien ther th				e (First, Middle, Ma		ocery Store
ryland	should be filad wand Mental Hygiers smarkad other ti	To Be	James Madison Myrick, Sr.	Olive		Ve	nner
	and 2 sh lealth and m 27 ls n her traun		Donna Marie Conway -daughter 5031	iling Address (Street and Number or Rur Mangum Road Colle	ge Park,	Maryland :	20740
Baltimore,	Pages 1 ment of H ent: If ite ury or ot	,	Cametery ci	position (Name of ematory or other place) n National Cemeter		oc. Location - City or 05 Arlingt	
Balt	permit. Depart Import eny inj		21. Signature of Funeral Service Licensee  Denald U, Brywart 4	gnald V. Borgwardt 400 Powder Mill Ro	Funeral ad Beltsv	Home, PA ille, Mary	land 20705
	Physician /Medical Examiner physician physicia	Examiner	23a. Part1. Enter the disease, or complications of caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Lung Cancer  Due to (or as a consequence of):  Due to (or as a consequence of):  C	nter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
). Box 68760	ath certific attending p for use as	Physician/Medicai E	d	□Ectopic pregnancy		23d. Date of deliv	very Day Year
1s, P.O.	ires that the de signad by the a 1 ba detached	by	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the Emphysema; stroke; pneumonia; hypothy			cco use contribute to	the cause of death?
Records,	w require been si should l	ietec	syndrome of inappropriate antidiuret				
tal Ke		e Compieted	25. Was case referred to medical		performe	d? prior to co death? I No 1 ☐ Yes	opsy findings available ompletion of cause of
<u> </u>	lysicie is cert direct	To B	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Other	n <i>(Ch</i> eck only one) me 5 <b>X</b> Residend	ce 6 □Other (Speci	ifv)
Division of Vital	nding Ph ath. r: After th e funeral		27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident investigation  28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how		
DIVIS	Hospital or Attending Physicien: 44 hours after death. Funeral Director: After this certificately filled in by the funeral director,	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	To the Hospital or within 24 hours after To the Funerel Dire completely filled in b	Medicai (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal of the basis of examination and/or in and manner stated.	ath occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as and place, and due to	stated. to the cause(s)
	To that within 2 To the complete	Z	29b. Signature and title of certifier  A Michael D. Denslaver	29c. License number D39838		Date signed (Month, pril 14, 2	
	10		30. Name and address of person who completed cause of death (Item 23a) (Type Michael J. Furlong, MD 10810 Connect.	o. Print) icut Avenue Kensing	gton, Mar	yland 2089	5
	Sta Registr	te ar		perli			

		·	For State Registrar		aryland / Dep		Health and Me Death	ental Hygi	•	5 1469
	nysicia Medic		1. Decedent's Name (First, Middle George		thison	, J		2. Date of Death Month		3. Time of Death 5 2055 M
	xamin		4a. Facility Name (If not institution, Heron Point			Chest	or Location of Death	1	4c. County of Dea	2 -
	neral ector		5. Social Security Number 120-14-7816  Usual Residence of Decedent	6. Sex 7. Ag 1 XM 2 ☐ F	e (In yrs. last birthday 79 Yrs.	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept. 2:	9. Bi	rthplace (State or Foreign Country)
with the Maryland a or 28a-f show	be notified at	tor	10a. State 10b. County MD Kent		10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
th with the Ma 23a or 28a-f	st be not	ai Director	10e. Street and Number 203 Maplewood	l Lane	1	10f. Zip Code 21635		10	g. Citizen of What C	Country?
ter dea	minerm	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Amed Forces?  If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🖾 No	Hispanic Origin? (Specian, Mexican, Puerto R Specify:	eify Yes or No- ican, etc.)	14. Race - Am Black, Wh Specify:Wh	ite, etc.
within ene.	he Medical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4or 5	(Give	edent's Usual Occup e kind of work done DO NOT use retire Lstant Di	during most of working ad)	g 1	6b. Kind of Business	•
nd 2 should be filed th and Mental Hygi 27 is marked other	atic event,	To Be C	17. Father's Name (First, Middle, L George Mathis	son				e Taft		
27 E 27	5		19a. Informant's Name/Relationsh  Jodi Mathison  20a. Method of Disposition			Maplewoo	d Lane, Ga	lena, M	21635	
Dermit. Pages 1 a Department of Hea Important: If Item	njury or		1 ☐ Burial 2 🂢 Cremation  '4 ☐ Donation 5 ☐ Other (Sp.  21. Signature of Funeral Service L	ecify)	Chesapeal	matory or other pla ce Cremat	ion Apr 1	9,2005	oc. Location - City or Stevenesvi	ille, MD
Depart of the control	any ii		from fellow							Home, P.A.
Physic / Med Exam	lical liner	Jicai Examiner	23a, art1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CEREM  Due to (or as  Due to (or as	10.		ACUDE		31.	Approximate Interval Between Onset and Death IS MS > 7 years
The law requires that the death certificate be executed its has been signed by the attending physician and	d be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc	у		23d. Date of de Month	livery Day Year
equires that the consigned by the	pec	þ	Part II. Other significant condition	s contributing to death b	ut not resulting in the u	inderlying cause grv	ren in Part I.	23e. Did toba	,	o the cause of death?
The law requires t	page 2 sho	Completed						24a. Was an autopsy performs	prior to	utopsy findings available completion of cause of
Physician: r this certific	lirector,		25. Was case referred to medical examiner? 1 ☐ Yes 25. No	Hospital: 1 ☐ Inpatie	nt 2□ER/Outpatie	nt 3□ DOA Oth	26. Place of Death (	Check only one)		
l or Attending Physician: 1 after death. Diractor: After this certifical	funera		27. Manner of Death  1 Natural 5 Pending 2 Accident investigs 3 Suicide 6 Could no	28a. Date of Inju. (Month, Date)		f 28c. Injur Wor M 1	yat 28 k? Yes 2 □No	d. Describe how	ce 6 Other (Spe	
To the Hospital or Attend within 24 hours after death To the Funeral Diractor:	filled in b	al Certi	4 Homicide determine 29a. Certifier	Physician: To the best	c. (Specify)	h occurred at the tir	me date and place an	City or Town,	State)	ctated
To the Hospital or within 24 hours afte To tha Funeral Dir	completely	Medical	(Check only 2 Medicel E one)  29b. Signature and title of certifier	xaminer: On the basis of and manner sta	examination and/or in	vestigation, in my o	pinion, death occurred	at the time, date	a and place, and due	to the cause(s)
		-	30. Name and address of person w	the completed cause of di	eath (Item 23a) (Type	Print)	0041587			2005
			Heien A.	Noble	MD 1	22 Spe	er Rel Cl	restat	con mo	21620
1	Stat	e	31. Date filed (Month, Day, Year)	ALC:	ar's Signature	A. M.			·	

		1 - For State Registrar	te of Marylan		artment of He			giene 20	05 1469
٥.		Decedent's Name (First, Middle, Last)					2. Date of Dea	th	3. Time of Death
Physic /Med		Adelaide Virginia	McIntire				April	10 200	05 0107 M
Exami		4a. Facility Name (If not institution, give street			4b. City, Town, or	Location of Deatl	n	4c. County of	
		Carroll Hospital Cen	ter		Westm	inster		Car	croll
Funera	1	5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	Birthplace (State or Foreign Country)
Director		216-30-3414 1 I M 2	82 82	Yrs.	luonais Days	Tiodis Willi.	Oct 21	1922	MD
pu 🛾		Usual Residence of Decedent  10a. State 10b. County	10c Cit	ty, Town or Lo	cation				10d. Inside City Limits
shor	\ <u>`</u>								1 ☐ Yes 2 No
he N	Director	Fla Okaloosa		Crestv					
With t	늄	10e. Street and Number			10f. Zip Code	256		10g. Citizen of Wh	
a 23	Funeral	123 Arapaho Trail	as Decedent Ever in U	C 112.1		356	nooit. Van en Na	USA	American Indian,
ter de	Ë	An	ned Forces? ]Yes 2 □ Mo	.5.	Was Decedent of His f Yes, specify Cubar	n, Mexican, Puert	o Rican, etc.)		White, etc.
Irs af	by F	3 Widowed 4 □ Divorced Ye	es, Give ar or Dates:		1⊡Yes 2½∑No	Specify:		Specify:	White
to bou		15. Decedent's Education			dent's Usual Occupa			16b. Kind of Busi	ness/Industry
o se co	Completed	(Specify only highest grade complete Elementary/Secondary (0-12)	eleted)	(Give	kind of work done d DO NOT use retired)	uring most of wor	rking		,
yiene rith	E	9	11ege (1-4or 5+)	H	omemaker			Own Ho	ome.
ent,	a)	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	
TOTE, INICITY INITY ALL ALL S-UDOO  ges 1 and 2 should be filed within 72 hours after deeth with the Maryland  tof Health and Mental Hygiene  if Item 27 is marked other than "natural", or Itema 23a or 28a-f show  or other traumatic event, the Medical Examinar must be notified at	To B	Eldridge T. Simms				Glady	s S. Joh	nson	
shou and N uma		19a. Informant's Name/Relationship (Type, Pr	int)		ng Address (Street a		iral Route Numbe	r, City or Town, St	ate, Zip Code)
alth a		Barbara Frock/daught	er	129	Houck Road	d Westm	unster,	MD 2115	7
Sta Sta		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of natory or other place	)	Date	20c. Location - Ci	ity or Town, State
Page lent c nt: If ry or		1   Burial 2 □ Cremation 3 □ Remove  4 □ Donation 5 □ Other (Specify)	ai from State		ranch Cem		/13/2005	Westmi	nster, MD
Dallinore, Ma permit. Pages 1 and 2 Depertment of Health a Important; if Item 27 is any Injury or other tra once.	i	21. Signature of Junesal Service Licensee			Name and Address Pritts Fu	1 -			
Depending any la		Marly El-			412 Washi	neral Ho	ome and C	napel, P	'•A• 21157
		23a. Part 1. Enter the disease, or complication	s that caused the deat	th. Do not ent	er the mode of dying	, such as cardiad	or respiratory ari	est,	Approximate
Physician		shock, or heart failure. List only one cau Immediate Cause (Final	se on each line.						Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consec	mence of).					
Examiner	r	Due to (or as a consequence of):							
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):					
uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	C. A.D						
exec n an ial-tr	Exa		Due to (or as a conseq		1.				
COLDS, F.O. BOX DO/OU, wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dicai	d	Atrial	+14	Millatio	h			
oo iifical g ph) as th	edi	127							
ath cer attendin for use	hysician/Me		res, outcome of pregna		Ectopic pregnancy			23d. Date	of delivery
death death e atten	Cia	in the past 12 months?	Pregnant at time of o		Other (specify)		<del></del>	Month	n Day Year
by the tache	hys	9 Unknown	Unknown						
ords, F.C requires that the een signed by th hould be detache	by P	Part II. Other significant conditions contribut	ng to death but not res	sulting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
w require							1 □ Y	es 2□No 3	☐ Probably 4 ☐ Unknown
lawre as bec	ompieted						24a. Was a		ere autopsy findings available
<b>→</b> 0 ← 0	Eo						autop: perfor	med? dea	or to completion of cause of ath? ☑ Yes  2 ☑ No
VICAL P. Ilcian: The certificate	O	25. Was case referred to medical				26. Place of Dea	ath (Check only or		7103 2010
S C	0 8	examiner?	il: 1 hpatient 2	ER/Outpatier	t 3 DOA Othe	r		ence 6 Other	(Specify)
on or ding Phye th. After this funeral di	i.	27. Manner of Death 28a	. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work	at		ow injury occurred	
ath. Aft	atio	1 Natural 5 Pending 2 Accident investigation	(Monar, Day roar)	Injury		es 2 □ No			
OVISION  or Attending after death. Director: Afte	ertificatio	3 Suicide 6 Could not be determined 286	e. Place of Injury - At h building, etc. (Special	ome, farm, str	eet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
DIVISION SPITE OF THE OUTS After death outs after death or all of the outs filled in by the	Cert		building, etc. (Specia	· <b>y</b> /			0.19 0.70	n, State)	
ospli hour unere ly fille	क	29a. Certifier 1 Certifying Physician (Check only 2 Medical Examiner: 0	To the best of my kno	owledge, deatl	occurred at the time	e, date and place	, and due to the o	ause(s) and mann	ier as stated.
LIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edic		n the basis of examina nd manner stated.	and/or in	vestigation, in my op	IIIOII, GEAIN OCCU	med at the time, c	ate and place, and	J due to the cause(s)
T Viji	Σ	29b. Signature and title of certifier	0100 1	IIN	29c. License	number	210 2	9d. Date signed (	Month, Day, Year)
MIL		THUCCH	LUG !	W.	17 - 1	0034	418	04-10	1-05
10		30. Name and address of person who complet	1 / -	п 23а) (Туре,	Print)	. 0 .			
		DR. Raman B	Kanena,	349	MacColv	y dell	e, we	thurster	Mp 21159
	tate	31. Date filed (Month, Day, Year) APR 1 2 200	32. Registrar's Signa	ature					
Regis	trar	APR 1 2 200	Electra	K	Somet.				

			1 - For State Registrar	State of Ma	aryland / I		artment of H		ind Me		giene Reg. No.	me da 162 173	14698
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last)  JAMES G		MANI	DR				2. Date of De Month April	11, Day	2005	3. Time of Death 21:15 P M
	Examin	er	4a. Facility Name (If not institution, give s Greater Baltimore  5. Social Security Number 6. Sex	Medical	e (In yrs. last bi	rthday) Yrs.	4b. City, Town, or  Towson  If Under 1 Year  Months Days	If Under 2	24 Hrs.	8. Date of Bir (Month, Da July 1	Ba	County of Deat	thplace (State or Foreign
	Director woys	j.	Usual Residence of Decedent  10a. State 10b. County	90	10c. City, Tow					July 1	0, 1	914 Gr <b>e</b>	10d. Inside City Limits
	with the Ma Na or 28a-f	Funeral Director	Maryland Baltimore  10e. Street and Number  9847 Magledt Road	2			10f. Zip Code 212	1 <b>ti</b> mo	re			zen of What Co	puntry?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If itam 27 is marked other than "natural", or itama 23a or 28a-f show or other traumatic evant, the Medical Examinating Le modified at	by		2. Was Decedent & Armed Forces? 1 Yes 2 X N If Yes, Give Year or Dates:	Ever in U.S.	1	Was Decedent of Hi f Yes, specify Cubar I □ Yes 2 X No	spanic Orig n, Mexican	in? (Spec , Puerto R	rify Yes or No lican, etc.)		14. Race - Ame Black, White Specify: Wh	erican Indian, e, etc.
121	within 72 houlene. than "nature the Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)			(Give	dent's Usual Occupa kind of work done o DO NOT use retired, arpenter	ation furing most )	of working	9		nd of Business/	(Industry
2	should be filed nd Mental Hygi marked other umatic evant, I	To Be Co	17. Father's Name (First, Middle, Last)  George Nicholas Man					Staur	oula	(First, Middle,	Maiden	Sumame)	
as	ges 1 and 2 st t of Health and If itam 27 Is n or other traun		19a. Informant's Name/Relationship (Ty)  Christine Turner /  20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ R	Daughter	20b. Place of cemete	5 Foot Dispo	og Address (Street a OX Ride sition (Name of natory or other place	Drive	Ma.	lvern,	PA 20c. Lo	19355 cation - City or	Town, State
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ott		4 □Donation 5 □Other (Specify)  21. Signature of Furlers, Service License		St. D	22	trius Cem Name and Addres 7 Duke of	s of Facility	Jol		Tay 1	or Fune	Maryland ral Home MD 21401
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each lin . Pneum	the death. Do ne. nothore a consequence	a×.	er the mode of dying	g, such as (	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death Commonwes
8760,	icate be executed physician and sthe burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events resulting in death) Last	Dus to (ur as	a consequence					-			
Box 6	that the death certifica ed by the attending pt detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)				2	23d. Date of del Month	ivery Day Year
S	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death bu	ut not resulting i	in the u	nderlying cause give	en in Part I.			obacco u Yes 2[		the cause of death?
<u> </u>	The law ate has b page 2 sl	Completed	25. W							1 ☐ Yes	osy rmed? 200 No	24b. Were au prior to death?	atopsy findings available completion of cause of
ō	Attanding Physician: r death. sctor: After this certific by the funeral director.	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2No Hanner of Death Natural 5 Pending 2 Accident investigation	ospital: Datinpatie  28a. Date of Injur (Month, Day	ry 28b.	utpatien Time of Injury	28c. Injury Work	or: 4 □ Nur	sing Hom	(Check only of e 5 ☐ Resid 3d. Describe l	dence (	3 □Other (Spec	cify)
Division	in Pite	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc	c. (Specify)		eet, factory, office			City or Tox	vn, State,	)	ıral Route Number,
	To the Hospital within 24 hours a To the Funaral I completely filled	Medical	29a. Certifier (Check only one)  2 Medicel Exeminates  29b. Signature and title of pertifier	ner: On the best of ner: On the basis of and manner sta	examination ar	e, death	occurred at the tim vestigation, in my op 29c. License	oinion, deat	place, ar h occurred	d at the time,	date and	and manner as place, and due e signed (Mont)	to the cause(s)
	<u> </u>		30. Name and address of person who co	Solia	- MD	/Tuna	DOC		453		Apri	1 12 a	2005
100	Sta Regista	• 15	Dr. Anastasios Sal 31. Date filed (Month, Day, Year)	iaris (		Cha	Analls Stre	eet, 1	Room	3853	Bal	timore,	MD 21204

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 12<sup>0</sup> 2005 Margaret Elizabeth Meisel 5:25 Αм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Corsica Hills Ctr Centreville Queen Anne's If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Nov. 23, 1914 **Funeral**  Birthplace (State or Foreign
Country) Days Hours Min 1 M 2004F 90 217-18-0615 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any follow or other traumatic event, The Medical Examinations or 28a-1 show once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Queen Anne's Stevensville Maryland 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 306 Columbia Lane 21666 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married þ If Yes, Give Year or Dates: 1943-44 1 ☐ Yes 2 X No Specify: White Specify: 3€Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done du life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) 8 Owner Beauty Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Jacobson Anna Yost P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence Dryer/daughter 306 Columbia Lane Stevensville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Meadewridge Mem. Park 4/16/2005 Elkridge, Maryland <sup>4</sup> □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated accounts) Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed peen 24a. Was an autopsy performed?
1 Yes 2 PNo 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 1 E Natural 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation efter death Director: the 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral ( ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2536 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who cos Draw 2108 31. Date liled (Month, Day, Year) 32. Reg rar's Signature State Registrar

	•	1 - For Stata Ragistrar	Ce	artment of Health and I	Re	eg. No 005	14700
Physic		Decedent's Name (First, Middle, La     CHESTER JOHN	MACKAVAGE		2. Date of Deat	h Pay Year	3. Time of Death
/Medi Examir		4a. Facility Name (If not institution, giv		4b. City, Town, or Location of Deat	1/1/2/11	4c. County of Death	1418011
		DOCTOR'S COMMUNIT	Y HOSPITAL	LANHAM		PRINCE GEO	RGE'S
Funeral Director		5. Social Security Number 6. S 205-36-2698 1 Usual Residence of Decedent	ex 7. Age (In yrs. last birthday, ▼ M 2□ F 58 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, SEP 10,		ice (State or Foreigr y) ISYLVANIA
yland		10a. State 10b. County	10c. City, Town or L	ocation		10	d. Inside City Limits
th with the Marylar 23a or 28e-f show ast be notified at	Funeral Director		GEORGE'S	LANHA	ΔM		1 X Yes 2 No
with the	Dire	10e. Street and Number 5808 SHEPHERD LAN	T.	10f. Zip Code 20706		0g. Citizen of What Countr	y?
ms 23	eral	11. Marital Status				U.S.A.	n Indian.
permit. Pages 1 and 2 should be liled within 72 hours atter death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene.  any injury or other treumatic event, It e Macheal Examiner must be notified at other.	by Fur	1 Never Married 2 🕅 Married 3 Widowed 4 Divorced	Armed Forces?  1 X Yes 2 No If Yes, Give Year or Dates: 1964-1969	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert  1 ☐ Yes 2 No Specify:	o Rican, etc.)	Black, White, et	tc.
72 hc	Completed by	15. Decedent's Ed (Specify only highest gra	ducation 16a. Dece de completed) (Give	dent's Usual Occupation a kind of work done during most of wor DO NOT use retired)	king	16b. Kind of Business/Indu	istry
within iene. than "	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)			DED GO INTE ANT	
Hygie other	a l	17. Father's Name (First, Middle, Last,		JREMENT SPECALIST  18. Mother's Nan	ne (First, Middle, M	<u>PEPCO/MIRANT</u> Maiden Sumame)	
2 should be and Mental Is marked c	To B	CHARLES JOHN MACK	AVAGE	HELEN	ARASIM		
2 sho and 1 Is ma		19a. Informant's Name/Relationship (		ng Address (Street and Number or Ru			Code)
1 and 2 Health tem 27 l	1	PATRICIA A. MACKA  20a. Method of Disposition	VAGE/WIFE 5808 20b. Place of Disp	SHEPHERD LANE, LA	_		
Pages nent of H int: If ite		1 ☐ Burial 2 X Cremation 3 ☐	Removal from State cemetery, cre	matory or other place)		20c. Location - City or Tow	
permit. Pag Department Important: I any injury c		<ul><li>4 □ Donation 5 □ Other (Specify</li><li>21. Signature of Funeral Service Licer</li></ul>		EMATORY 4/1.  2. Name and Address of Facility ROB		ALDORF, MARY	
permit. Departn Imports any inju		1 Jal 7 Kund	e i	000 ANNAPOLIS ROA			20715
Physician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Me tustatic C  Due to (or as a consequence of):  Anoxic C		-	- I	Approximate interval Between Onset and Death
ate be executed hysician and the burial-transit	cal Examiner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  c.  Due to (or as a consequence of):  d.	a practical part	7		
tificat ng phy as th		The second of					
The law requires that the death certificat tie has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month D	ay Year
s that ined b e deta			ontributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to the	cause of death?
w require been sig should b	edt	Condiac	west.		1 ☐ Yes	s 251No 3 Probab	oly 4 □Unknown
	Completed by				24a. Was an autopsy perform	prior to comp	y findings available detion of cause of
Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Ost	th (Check only one		
this ral di	5	1 Yes 2 No  27. Manner of Death	1 Depatient 2 ☐ ER/Outpatier 28a. Date of Injury 28b. Time o	-	ome 5 Residen	nce 6 Other (Specify)	
r death. ector: After thi by the funeral	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Work? M 1 □ Yes 2 □ No	200. Describe 1107	w injury occurred	
Die	Certification;	3 Surcide 6 Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural F State)	Route Number,
to the hospitel or within 24 hours afte To the Funeral Dirt completely filled in I	Medical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowledge, deat iner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cau red at the time, dat	use(s) and manner as state te and place, and due to th	ed. le cause(s)
vithin To the	Σ	29b. Signature and title of certifier		29c. License number		d. Date signed (Month, Da	y, Year)
			anona MD	D2010	8 6	710910	5
			completed cause of death (Item 23a) (Type,				
		DVALCH VDUDV W D	. 14300 GALLANT FOX	LANE SHITE 222 RO	WIE. MD 2	20715	

		State of Maryland / De	partment of Health and Mertificate of Death	-	2005 16701
Physici /Media Examir	cal	1. Decedent's Name (First, Middle, Last)  Christine Maric  4a. Facility Name (If not institution, give street and number)  Johns Hapkins Hospital	Cushman Novara  4b. City, Town, or Location of Death Baltimore	April 13,	ay Year 3. Time of Death 133 to PM c. County of Death
Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Ment	8. Date of Birth	9. Birthplace (State or Foreign Washamgron, D.C.
the Marylan 28a-f show	rector	10a. State 10b. County 10c. City, Town or Kensing:  10a. State 10b. County 10c. City, Town or Kensing:	Location LOII	10a. C	10d. Inside City Limits 1 □ Yes 2 → No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show many injury or other traumatic event, the Medicul Everth artmissible field of ance.	by Funeral Director	3709 Lawrence Avenue	20895  3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F		USA  14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036 od within 72 hours aff gjene. er than "natural", or tre Medicul Every	Completed	(Specify only highest grade completed) (Gi	sedent's Usual Occupation ve kind of work done during most of workin . DO NOT use retired) CCOUNTANT	)g	Kind of Business/Industry
Maryland 2121: Id 2 should be filed within ith and Mental Hygiene. 27 is marked other than "traumatic event, the Men	To Be C			(First, Middle, Maide Le Jackson	
Baltimore, Mar, opermit. Pages 1 and 2 sho opermit. Pages 1 and 2 sho operatment of Health and mportant: If item 27 is m any injury or other traum.		Vincent J. Novara / Husband 3709  20a. Method of Disposition Burial 2 Cremation 3 Removal from State 20b. Place of Discomptery, Company Compan	Lawrence Avenue Kensing position (Name of rematory or other place)	ton, Marylar	
Baltimore permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licensee	22. Name and Address of Facility George 6160 Oxon Hill Road Oxo	P. Kalas Fur n Hill, Mary	
Box 68 760, eath certificate be executed XX XX XX XX XX XX XX XX XX XX XX XX XX	ical Examiner	23a. Part. Exist the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		respiratory arrest,	Approximate Interval Batween Onset and Death One week
The COTOS, P.O. BOX 08/00,  The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	by Physician/Med		B⊟Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
cords, P.O. I wrequires that the deben signed by the a should be detached?	ted by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death?
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DIVISION OF VITAL HE( I or Attending Physician: The lav after death. Director: After this certificate has tin by the funeral director, page 2	Certification: To Be	25. Was case referred to medical examiner?  1  Yes	of 28c. Injury at Work? M 1 Yes 2 No	ne 5 Residence 8d. Describe how inju	
DIVISIC  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only  (Ch	ath occurred at the time, date and place, a	City or Town, Star	s) and manner as stated
To the I	Medical	29b. Signature and title of certifier  Audille MD	29c. License number RES - 000	29d. D.	ate signed (Month, Day, Year)
Sta Regist		30. Name and address of person who completed cause of death (Item 23a) (Typ Lara Withne, Johns Hopkins Hospital), (2) 31. Date filed (Month, Day, Year) 37. Registrar's Signature		t, Balhmor	e, Maryland 21287

	1	For State Registrar			d / Depa		lealth and	Mental Hyg	•	05	14702
Physiciar		. Decedent's Name (First, Middle, Last,	Berta Y	NOV	ידע			2. Date of Dea Month	th Day	Year	3. Time of Death
/Medica Examine	1	a. Facility Name (If not institution, give Hebrew Home of Gre	street and number)			4b. City, Town, o Rockvi			3, 200 4c. County Monts	of Death	11:00 Ам
Funeral Director		3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	7. Ag	e (In yrs. la <b>9</b> 8	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		1907	9. Birthi Rus	place (State or Foreign ntry) SIA
Maryland -f show	1	Usual Residence of Decedent  Oa. State  10b. County  DC			, Town or Lo						10d. Inside City Limits
3a or 28a		0e. Street and Number 4000 Tunlaw Road	, NW, #11			10f. Zip Code 20007		1	10g. Citizen of		ntry?
	by rur	1. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		1	Was Decedent of H If Yes, specify Cuba  1 ☐ Yes 2 ☐ No	ispanic Origin? ( In, Mexican, Pue Specify:	(Specify Yes or No- arto Rican, etc.)	Bla	ce - Americk, White,	etc.
s within 72 ho liene. r than "netu	сошрієте	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5	5+)	(Give lite. I	dent's Usual Occup kind of work done DO NOT use retired Smaker	during most of w	vorking	16b. Kind of B		dustry
Viana A		7. Father's Name (First, Middle, Last) Yakovle	vna Novik					ame (First, Middle, Leah Per		ne)	
y Mar and 2 shd saith and n 27 is m		19a. Informant's Name/Relationship (T) Dmitry Novik, Son	rpe, Print)		4000	Tunlaw R		Rural Route Numbel			
Dallimore Demit. Pages 1 Department of Hc mportent: if iter iny injury or oth	2	20a. Method of Disposition 1 □ Burial 2 ②Cremation 3 □F 14 □ Donation 5 □ Other (Specify)	Removal from State	CE	emetery, crer	sition (Name of matory or other place Itan Crem			20c. Location Alexar		
Dail permit. Depart import any inj once.	-	21. Signature of Funeral Service Vicens		5				Funeral		DC :	20012
*Physician /Medical		23a. a first the disease, or complete show, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	ications that caused ne cause on each line.  Due to (or as	he. Lic	Do not ent		g, such as cardi				Approximate Interval Between Onset and Death
Examiner	Lec	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lauce (Diesako or injury	b. Due to (or as								
If <b>ou,</b> Ite be execute lysician and he burial-trans	ical Exa	cause Creases of Injury that initiated events resulting in death) Last	Due to (or as	a consequ	ience of):						
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1⊟Live birth 4⊟Pregnant at 9⊟ Unknown	2 Fetal	death 3	Ectopic pregnancy	,			ite of deliver	ery Day Year
w requires that been signed to should be detailed.	, מ	Part II. Other significant conditions co	htributing to death b Grilla L'o		ılting in the u	nderlying cause giv	en in Part I.				ne cause of death?
The law recate hes becate  and the second se	сотрыете							24a. Was a autops perform	sy med?/	Were auto prior to co death? 1  Yes	psy findings available mpletion of cause of 2 No
VICAL  sician: 1  certifical irector, p	o c	25. Was case referred to medical examiner?	Hospital:			Oth		eath (Check only on			
Attending Physical displayments of the function of the functio	-	1 Yes 2 No '  7 Mann Death 1 1 atural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry	ER/Outpatien 28b. Time of Injury	f 28c. Injur Wor	4 Line Mursing  y at k?  Yes 2 □ No	Home 5 Reside			y)
DIVISION ei or Attending s after death. Il Director: Afte d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At ho c. (Specify	me, farm, str	eet, factory, office		28f. Location (St City or Town	treet and Numi n, State)	ber or Rura	l Route Number,
n 24 hours n 24 hours he Funere		29a. Certifier 1. Certifying Phy (Check only one)	sician: To the best ner: On the basis of and manner sta	f examinat	wledge, death ion and/or in	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occ	ce, and due to the courred at the time, d	ause(s) and malate and place,	anner as s and due to	tated. o the cause(s)
To ti withii To ti comp		29b. Signature and title of certifier  Sec. 3	wie_			29c. Licens	e unmper	2	9d. Date signe		Day, Year)
1	- 1	30. Name and address of person who co		,	, , , .	Print)		20052	1111		
State Registra	e r	Gary Wilks, M.D., 31. Date filed (Month, Day, Year) APR 15 2	005 32. Segistr	ar's Signat	A A	NUCKVII	re, MD	20852			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 per Dr., (243,05/2/100000). Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** William R. O'Connell /Medical April 9 2005 7:30P 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 🔯 M 2 🗆 F b52-01-2932 Yrs. Director 87 July 12,1917 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If them 27 is marked other than "natural", or items 23s or 28s-f show ary or other traumatic event, the Medical Examination into the indiffer at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XXNo Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7101 Bay Front Drive, #111 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vice President 12 Shipping Lines 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William R. O'Connell, Sr. Delia Hernon 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Hirsch / Daughter 948 Melvin Road, Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department c Important: if any Injury or once. Baltimore Crematory 4/12/05 Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility John M. Taylor Funeral Home, Nichell 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arrhythma **Physician** 1 Must disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): ince thank! In 196 Ivision of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 2 🗆 No be detached 9 Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Triknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No Certification: To 2 ER/Outpatient 3 X DOA 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 1 ☐ Yes 2 ☐ No hours after death. uneral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide within 24 hours a To the Funeral L the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)30718 04-11-2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) le 2180/ Acceptalis. TJackan

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle, Last) 3. Time of Death Month **Physician** 11:15 a.m. 2005 18. Thelma Peace Ortmver Apri1 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** Months Days 1 ☐ M 2 등 F Yrs. Director 85 Jul.19, 1919 Australia 214-34-6998 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or than "neturel", or iteme 23e or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Funeral Director Lexington Park Maryland St. Mary's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20653 21625 Columbia Street United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or item any njury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White by 3 € Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail 12 Sales Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth Gwendolyn Price Hurtle Lehne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Harvey W. Ortmyer / Son 21625 Columbia Street, Lexington Park, MD 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Brinsfield-Echols Cr. 4-19-2005 Charlotte Hall, MD 4 □ Donation 5 □ Other (Specify 21. Signature Funeral concession of the Edward N. Brinsfield, Jr. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-02/9 M00052 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician del /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or aş a consequence of Examiner The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 4☐Pregnant at time of death the 9 Unknown 9 Unknowń ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed ģ 1 ☐ Yes 2 ② No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 2 No 1 Yes 1 Yes 2 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA P 2 7 No this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 📶 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

5/10 4

DHMH 17 Rev 1/2001

State

Registrar

24035 Three Notch Road, Hollywood, Maryland 20636

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jarboe,

Patrick

31. Date filed (Morith, Day, Year) 1

M.D.,

2005

32. Regis

			Department of Health and N  Certificate of Death	Mental Hygie	9
Physici /Medic		1. Decedent's Name (First, Middle, Last)  Garnet O. Pearson		2. Date of Death Month April 14	Day Year 4, 2005 7:50 p
Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		Laurel Regional Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last b.	irthday) If Under 1 Year   If Under 24 Hrs.	O Data of Birth	Prince George's
Funeral Director		216-22-7589 1□ M 2♥ 78  Usual Residence of Decedent	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y) Sept. 25,	(ear) 9. Birthplace (State or Foreig Country) 1926 Maryland
be tiled within 72 hours after death with the Maryland ital Hygiene. Id other then "naturel", or Items 23a or 28a-f show event, if e Mcdical Examinet must be motified at	Funeral Director		r Marlboro  10f. Zip Code  2077 2  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerio	Ţ	10d. Inside City Limits  1 ☑ Yes 2 ☐ No  1. Citizen of What Country?  J • S • A •  14. Race - American Indian, Black, White, etc.
urel', or It	Ď	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🖾 No Specify:		Specify: White
within 72 h ene. then "natu	Completed	College (1-40r 5+)	Decedent's Usual Occupation     (Give kind of work done during most of work life. DO NOT use retired)	ing 16	b. Kind of Business/Industry
filed v Hygie ther t	Co	8 K. 17. Father's Name (First, Middle, Last)	itchen Help	e (First, Middle, Ma	Magnolia Gardens
should be nd Mental marked c	To Be	Thomas Daniel Knight	Mary Mye		adn damand,
shou and M and M and M	-		b. Mailing Address (Street and Number or Run		City or Town, State, Zip Code)
and 2 saith a n 27 i		Eugene E. Pearson, Jr Son	4700 Governor Ogle Co	urt, Uppe	er Marlboro, MD 2077
permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 Ie marked any injury or other treumatic es <u>once</u> .		20a. Method of Disposition 1 \$\overline{\mathbb{N}}\$ Burial 2 \$\overline{\mathbb{C}}\$ Cremation 3 \$\overline{\mathbb{R}}\$ Removal from State 20b. Place of cemeter 20b.	of Disposition (Name of ery, crematory or other place)	Date 20	c. Location - City or Town, State
Pag tment tent: jury o		`4 Donation 5 Other (Specify) Fort	Lincoln Cemetery 4/18		Brentwood, Maryland
permit Depar Impor Impor any in		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ga		•
403 40	H	23a. Part1. Enter the disease, or complications that caused the death. Do	4739 Baltimore Ave		
Physician //Medical Examiner  physician and physician and the price is a second of the price is a second of the price is a second of the physician and in the price is a second of the physician and in the physician and p	icai Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Pneumonia  Due to (or as a consequence consequence)  Sepsis  Due to (or as a consequence consequence)  c.  Due to (or as a consequence)	of):		Interval Between Onset and Death
Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   4   Pregnant at time of death   9   Unknown   10   Unknown   11   Live birth   2   Fetal death   12   Pregnant at time of death   13   Pregnant at time of death   13   Pregnant at time of death   14   Pregnant at time of death   15   Pregnant at ti	n 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
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The law re ate has bee page 2 sho	Completed	Failure		24a. Was an autopsy performed	
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ng Physi (fter this c uneral dire	on: To	27. Manner of Death 28a. Date of Injury 28b.	utpatient 3 DOA Other: 4 Nursing Hor Time of Injury Work?	me 5 Residence 28d. Describe how i	
To the Hospitel or Attending Physicien: The law within 24 bours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No arm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
le Hospit	edicai (	29a. Certifier (Check only one)  1 ⚠ Certifying Physician: To the best of my knowledge 2 ☐ Medical Examiner: On the basis of examination are and manner stated.	e, death occurred at the time, date and place, ad/or investigation, in my opinion, death occurr	and due to the caus ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To th within To th comp	Me	29b. Signature and itle of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
		> PSAcyle MO. Abtent	719. D42580	A	pril 15, 2005
		30. Name and address of person who completed cause of death (Item 23a) Parmjit Singh Aujla, M.D. 5632 Ar	(Type, Print) Inapolis Road, Suite	l3, Blade	nsburg, MD 20710
Sta Registr		APR 1 8 2005 32. Registrar's Signature	· ,		

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PEUSON GARNET

	_ 1	For State Registrar	State of N	Maryla		artmer <i>rtificat</i>			and M	lental Hy	gien Reg. No	/ 11	05	1470
Physicia (Modies	n	Decedent's Name (First, Middle,     DONALD ARTHU		10 J	R.					2. Date of De Month APRII		200	Year	3. Time of Death 11:37AM
/Medica Examine	er '	ta. Facility Name (If not institution, NATIONAL INST	-		ALTH	BE	THES					:. County o		
Funeral Director		5. Social Security Number  005-76-6291  Usual Residence of Decedent	5. Sex 1 ☐ XM 2 ☐ F	Age (In yrs	s. last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Feb. 2	th ay, Year, 1, 1	001	9. Birthp Coun	lace (State or Foreign try)
the Maryland	ctor	10a. State 10b. County  KY Warre	n		ity, Town or Lo	reen								0d. Inside City Limits  Y Yes 2 □ No
N with 1	급	1552 Virginia D	r.			10f. Zip	42101					tizen of Wh Inited		
and 21215-0036  be filed within 72 hours after death with the Maryland tital Hygiene. Id other than "natural; or Items 23a or 28a-1 show event, the Marulcal Examiran must be notified at	by Fur	11. Marital Status 1 □ Never Married 2 ② Marrie 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force d 1  Yes 2 figure 1 Yes, Give Year or Dates	? XNo		Was Dece If Yes, spe		spanic Oric n, Mexican Specify:	gin? (Spe i, Puerto	ocify Yes or No Rican, etc.)		14. Race	Americ White,	an Indian,
1215-C	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		r 5+)		kind of wo DO NOT u	ork done d se retired,	ition fu <i>ring most</i> )	of worki	ng		and of Busi		,
Ind 2121 be filed within tal Hygiene. d other then event, the M.	Be Co	12th 17. Father's Name (First, Middle, L	ast)		Truc	k Dri	ver	18. Mother	r's Name	(First, Middle	-			Lines
rylar hould be d Menta narked natic ev	0	Donald Arthur  19a. Informant's Name/Relationshi		Sr.	10h Maile	4 44		Conni			- 01			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours alf Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural; or any injury or other traumatic event, the Marical Event	1	Kathy Paladino  20a. Method of Disposition		20b.	1552	Virgi	nia .	Ave.	Bow	/ Route Numb ling Gr ate	reen		421	101
Pages Pages ment of ant: If I		1 ☑ Burial 2 ☐ Cremation 3 1 ☑ Donation 5 ☐ Other (Specific		° Ch Me	cemetery, cremand apel H morial	najory or d ill Gard	other place ens	<sup>9)</sup> 4.	-14-	2005				n, Ky
Balt permit. Departi Import		21. Signature of Funeral Service Li	Enshal	10	22	Name ar Marsh 4217	nd Addres 1a11 9th	s of Facility S Fun St. N	eral	Home, Washi	Inc			20011
Pnysician /Medical	-	23a. Fant. Enter the disease, of conditions, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	Massire	Du	lmmar	id Pau	bali	•		r respiratory a	rrest,			Approximate Interval Between Onset and Death
58760, crate be executed Experience be executed Experience and Experience is the burial-transit	es :	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a c. Due to (or a d.	thic a conse	PEMCI querios or):	rentic	ca Ca	ncer					1	.D years
Hecords, P.O. Box 68760,  The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	₩ -	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fet	al death 3□	Ectopic pr						23d. Date of Month		ry Day Year
rdS, P.		Part II, Other significant condition	s contributing to death	but not re	sulting in the u	nderlying c	ause give	n in Part I.			obacco i			e cause of death?
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f Vita yslcian: is certific director,	10 Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	ient 2	] ER/Outpatien	t 3 DC	Othe			Check on o		6 ∏Other	(Specify	)
Division of Vita With the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		27. Manner of Death  1 Natural 5 Pending 2 Accident investiga		ury ay Year)	28b. Time of Injury		8c. Injury Work		2	8d. Describe h			( 2 2 2 2 )	
DIVISION Ital or Attents after deat all Directors and in by the	Certification:	3 Suicide 6 Could no 4 Homicide determin		njury - At h atc. <i>(Speci</i>	ome, farm, str	eet, factory	r, office		2	8f. Location (S City or Tox			or Rural	Route Number,
To the Hospital or within 24 hours after completely filled in I		29a. Certifying (Check only one)  1  Certifying 2  Medical Expension	Physician: To the best taminer: On the basis and manner s	of examina	owledge, death ation and/or inv	occurred restigation	at the time in my opi	e, date and inion, death	place, a	nd due to the d d at the time,	cause(s) date and	and mann	er as sta d due to	ited. the cause(s)
To the within To the compl	Z :	29b. Signature and title of certifier		)			: License	number	615		29d. Dai	e signed (/		Pay, Year)
20	3	30. Name and address of person with the same and the same and the	no completed cause of				ER D	RIVE	, B	ETHESD	)A,	MARY	LAN	D 20892
State Registra	_	31. Date filed (Month, Day, Year)  APR 1 5 20		trar's Signi	ature	B					•			

			ricase	State of Marylan								Legible.		
			1 - For State Registrar	otato o marytan				Death		_	Reg. No.	200	5 14	70
П			1. Decedent's Name (First, Middle, La	st)					2.	Date of De	ath Day	Year	3. Time of	Death
	Physicia /Medic			M. Porter						pril	14	2005	1	A M
	Examin	er	4a. Facility Name (If not institution, give	_				Location of D			4c.	County of Deat		
Н			8909 Old Frederic  5. Social Security Number 6. S		last birthday)		r 1 Year	tt City	<del>-</del>	Date of Birt	th	Howard 9. Birt		or Foreign
	Funeral Director			™ <b>2K</b> □ F 75	Yrs.	Months	Days		Min.	(Month, Da	y, Year)	29 Wis	hptace (State of untry) CONSIN	7 1 0 0 g/.
7	D D		Usual Residence of Decedent		y, Town or Lo								,	in dimite
	ehov	'n	10a. State 10b. County										10d. Inside C	
	28a-f	Director	MD Howard  10e. Street and Number	<u>i</u>	Ellicot		p Code				10g. Citi:	zen of What Co	untry?	
	in 72 hours effer death with the Maryland "natural", or Items 23e or 28e-f ehow ledical Examiner must be notified at		8909 Old Frederic	ck Road				043				ited St		
	death	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Dece	edent of Hi	ispanic Origin n, Mexican, P	? (Specifi	y Yes or No		14. Race - Ame Black, Whit	rican Indian,	
2	hours efter tural', or Ita		1 Never Married 2 Marned	1 ☐ Yes 2 No		1 ☐ Yes		Specify:		,,		Specify:		
	hours tural',	ed by	3€ Widowed 4 Divorced  15. Decedent's E	Year or Dates:	16a. Dece	dant's Hs	ial Occup	ation				nd of Business	White	
'n	within 72 I iene. than "nat he Medica	piet	(Specify only highest gra	ade completed)	(Give	kind of w	ork done d use retired	furing most of	f working			ns Hopk:		
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yland	be filed tal Hygi d other event,	Be	17. Father's Name (First, Middle, Last,	)				18. Mother's			Maiden	Sumame)		
yıa		မ	Knute Ross					Anna (						
Mai	C1 00 = 00		19a. Informant's Name/Relationship (									Town, State, 2	Zip Code)	
a) D	1 an Heel Heel		Lizann M. Koechlin 20a. Method of Disposition		244Z Place of Dispo			anino	MUT.	rieta,		92562 cation - City or	Town, State	
Ē	80= 5		1 Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special	THORITONAL HORIT STATE	est Lat	matory or wn Me	other plac m. G	ard. 4	-20-2	2005	Marr	iottsvi	lle, M	<b>O</b>
Бапттог	보는 문문을 .		21. Signature of Funeral Service Licer	**							li+ok	e's Fan	nilsz FH	Tnc
ñ	Deps Deps Impo any i		I Diene Colle	s-little	4	112 (	ld C	olumbia	a Pil	ke Ell	icot	t City	MD 21	043
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.			2	1			rrest,	_	Approximat Interval Bet Onset and I	e ween
\$	Physician		Immediate Cause (Final disease or condition resulting in death)	a. 11º Rt	what	14 0	luso	lene / <	CAC	01			6 hc	xk/
	/Medical Examiner		Testing in dealin)	Due to (or as a conseq	uence of):				•					•
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	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
<b>,</b> 60,	be executed icien and burial-transit		resulting in death) Last	Due to (or as a consec	tuence of):									
9/89	e y s	dicai	•	_ d				<u></u>						
	certific ding p	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregna	ancv							23d. Date of del	iven	
ROX	death a atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🐼 No	1 Live birth 2 Feta 4 Pregnant at time of c	aldeath 3	□Ectopic   □ Other (s	pecify)				1	Month		Year
л О	at the de by the a tached	hys	9 Unknown	9□ Unknown										
	The law requires that the death certifica ite has been signed by the atlending ph bage 2 should be detached for use as th	by P	Part II. Other significent conditions	contributing to death but not res	sulting in the u	inderlying	cause give	en in Part I.				se contribute to		
Kecords,	requir een s hould	eted								יטי :	Yes 2	2m/o 3∐Pr	obably 4 🔲	Juknown
ec C	The law ate has b	Completed							_	24a. Was autop		24b. Were at prior to death?	llopsy findings completion of c	available ause of
_			25. Was case referred to medical							1 ☐ Yes	2 🔀 No		2 No	
5	ysician: is certific director,	To Be	examiner?	Hospital: 1 Inpatient 2	FB/Outpatie	nt 3 🗆 D	OA Oth	26. Place of				3 □Other (Spe	Cifu)	
סר	g Phy ter thi neral o		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injun Worl	/ at		1. Describe I			51147	
000	ttending I death. ctor: After y the funer	atio	1 XNatural 5 Pending 2 Accident investigatio	on	injury	М		Yes 2 □ No						
Division of	after deat Director:	Certification:	3 Suicide 6 Could not be determined		ome, farm, st fy)	reet, facto	ry, office		28f	. Location (S City or Tox	Street and wn, State,	d Number or Ru )	iral Route Num	ber,
	Hospitei 4 hours a Funeral C		29a. Certifier 1 Certifying Pl	hysician: To the best of my kno	nwledge deat	h occurre	d at the tin	ne date and r	place and	I due to the	cause(s)	and manner as	stated	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Example)	miner: On the basis of examina and manner stated.	ation and/or in	vestigatio	n, in my o	pinion, death	occurred	at the time,	date and	place, and due	to the cause(s	)
	To the within 2 To the comple!	Me	29b. Signature and title of certifier	1		25	c. License	e number			29d. Dat	e signed (Mont	h, Day, Year)	
1	50		In Chil	{			022	15	7		Aŗ	oril 15	2005	
100	2		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type,	Print)	0	. 1	,	/	11		1 .	
	Sta	oto	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	11/2/	ctuta	of Fort	hay	( e	lun G	ic Mari	lan/2	1044
	Sta Regist			2005 Alexan	de de	loras!	3							

			For State Registrar	State of Marylan	id / Depa		Health and M	lental Hygi	_	5 14708
			Decedent's Name (First, Middle, La	est)				2. Date of Death	1 _	3. Time of Death
	Physicia /Medic Examin	al	Richard 1 4a. Facility Name (If not institution, given	Darwin ve street and number)	Richa		or Location of Death	April	Day Year  18 2003  4c. County of Dea	7355 M
00	LAUIIIII		0	nal Medical G	enter	Sali	shull		Wicom	
32	Funeral Director		5. Social Security Number 6. S		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 06-22-1	Year) 9. Bit	rthplace (State or Foreign ountry) nnslyvania
30	and w		Usual Residence of Decedent  10a. State 10b. County	10c Cit	v. Town or Lo	cation				
3	death with the Maryland ms 23s or 28e-f show	Funeral Director	MD Somers			ss Anne	-			10d. Inside City Limits 1
H	with the	Dire	10e. Street and Number			10f. Zip Code	1050	10	g. Citizen of What C	ountry?
N	Jeath ms 23	eral	30550 Libby Lar	12. Was Decedent Ever in U	.S. 13. V		1853	ecify Yes or No-	USA 14. Race - Am	erican Indian
36	hours after of tural, or iter al Expenden	by Fun	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Yes, specify Cub I□Yes 2 (No	Hispanic Origin? (Spean, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	
215-0036	72	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give	lent's Usual Occup kind of work done OO NOT use retire	during most of work	ing 1	6b. Kind of Business	
212	d within giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+) none		Barber			Cosmetolog	ΣV
7 5	2 should be filed and Mental Hygid Is marked other aumatic event, I	Be (	17. Father's Name (First, Middle, Last	)			18. Mother's Name	(First, Middle, M	laiden Sumame)	
Ry is	should Ind Meni	2	Edward Richards						a Stocktor	
Az ra	12 sh h and 7 Is II		19a. Informant's Name/Relationship	, ,					City or Town, State,	
	1 and Healt Hem 2		Joanne Richards/V	20b. F	Place of Dispo	sition (Name of	] [	-	e, MD 2185	
ਟ ਮੁਕਾਟ altimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	semetery, cren	natory or other pla	ce)	_	-	
e 7	mit. F partm sortar / injui		21 Signature of Funeral Service Lice	. Dee		Cemeter  Name and Addre	y 04/23 ess of Facility deral Home		rincess Aı	nne, MD
, S m	P T P P	(	amen & XUI	NAL D MODE					ss Anne, 1	MD 21853
	Physician		23a Part 1. Enter the disease, or com shock, or heart failure. List only mmediate Cause (Final disease or condition resulting in death)		h. Do not ente	er the mode of dyir	ng, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in dealth)	Due to (or as a conseq	uence of):					
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	te be executed ysician and e buriat-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):					
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687	e % e			_ d						
Division of Vital Records, P.O. Box	To the Hospitel or Attending Phyalcian: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: Atter this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	ildeath 3□	Ectopic pregnance Other (specify)	у		23d. Date of de Month	livery Day Year
rds, P	quires that n signed b	ed by PI	Part II. Other significant conditions	contributing to death but not res	ulting in the ur	nderlying cause gru	ven in Part I.	23e. Did toba		o the cause of death?
000	law requii as been s 2 should	plete						24a. Was an	24b. Were a	utopsy findings available completion of cause of
al Re	ician: The l certificate ha ector, page	Completed						autopsy perform 1 Yes 2	ed?   death?	completion of cause of
Ş	yalclan: is certific director.	o Be	25. Was case referred to medical examiner?  1 \( \sum \) Yes 2 \( \sum \) No	Hospital: 1 Lippatient 2	EB/Outpation	t 3 DOA Ott	26. Place of Death			
of	g Phy er this eral c	h-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injur	ry at	ne 5 ☐ Hesider 28d. Describe hov	nce 6 Other (Spe winjury occurred	city)
io	Attending I death. ctor: After y the funer	atio	1 ☑ Natural 5 ☐ Pending investigation	n .	Injury	M 1	rk?  Yes 2∐No			
Divis	ei or Atte s after de il Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	eet, factory, office		28I. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	To the Hospitel or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	edical (	29a. Certifier (Check only one)	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death ition and/or inv	occurred at the tir restigation, in my o	me, date and place, a opinion, death occurr	and due to the car ed at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier		~~/	29c. Licens	se number	29	d. Date signed (Mont	h, Day, Year)
			30. Name and address of person who	mpleted cause of death (item  M. D. 100	n 23a) (Type, I	Print) Print)	55 11	Isbury	1 000	
	Sta	te	31. Date liled (Month, Day, Year)	32. Registrar's Signa			09	2017		
	Registr		APR 21		B.	beck				

			1 - State Registrar  Co	partment of Health and Nertificate of Death		Reg. No.	005	147	09
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of De.	Day	Year	3. Time of De	
	/Medic	al	Ralph S. Riggs, Jr.  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	HPMI		2005 tv of Death		Ям
1	Examir	er :	Good Samarilan Hospital	Baltimore		Bal	ty of Death	ne	
	Funeral		5. Social Security Number 220-60-2983 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year   If Under 24 Hrs. Months Days Hours Min.	8. Date of Bird (Month, Da	th y, Year)	9. Birthp	lace (State or Fo	oreign
	Director		Usual Residence of Decedent		04/25/1	1931	Was		C.
	show		10a. State 10b. County 10c. City, Town or	Location			1	Od. Inside City L	imits
	a-fs-	ctor	MD Baltimore Towson					1 🔀 Yes 2 [	□No
	or 28	Dire	10e. Street and Number	10f. Zip Code		10g. Citizen of	f What Coun	try?	
	s 23a	erai	7925 York Road  11. Marital Status 12. Was Decedent Ever in U.S. 13	21204	noofly Von or No	USA	ace - Americ	an Indian	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mentat Hygene. Ifeath and Mentat Hygene. Item 27 is marked other than "natural, or Items 23a or 28a-f show other traumatic event, the Medical Executivat must be recitified at	by Funeral Director	1 XNever Married 2 Married 1 Yes 2 XNo	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 X No Specify:</li> </ol>	Rican, etc.)		ack, White,	etc.	
8	2 hours	ted t	15. Decedent's Education 16a. De-	cedent's Usual Occupation	, .	16b. Kind of	Business/Inc	lustry	
215-0036	within 7: ene. than "n	Completed	(Specify only highest grade completed) (Gillife  Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work.  DO NOT use retired)	king				
7	filed wi Hygien ather th	Con		nployed  18. Mother's Nam	- /Fina adiddin	14-14-0		<u> </u>	
and	d be find H	Be c	17. Father's Name (First, Middle, Last)	Kathryn		маювп Зита	ime)		
, Maryland	2 should be filed withir and Menta! Hygiene. Is marked other then aumatic event, the M	2	Ralph S. Riggs, Sr.  19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Ma	iling Address (Street and Number or Ru		er, City or Town	n, State, Zip	Code)	
	1 and 2 Health a tem 27 is		John Harwell / Trustee 808	17th St. N.W., Was	hington,	DC 20	006		
Baltimore	of He of He If item or oth		YYOurist 2 Comption 3 Demoust from State cemetery, c	position (Name of rematory or other place)	Date	20c. Location	•		
ij	trant of tant: If it		'4 □Donation 5 □Other (Specify) Arlingto		72005			irginia	
Bal	permit. Pages 1 and Department of Heali Important: If item 2 any injury or other 20.05.		21. Signature of Funeral Service Licensee  M01378	22. Name and Address of Facility Jo. 5130 Wisconsin Av	-		-		)16
			233 Part1. Enter the disease of complications that caused the death. Do not eshock, or heart failure distributions on each line.	1	or respiratory ar	rrest,		Approximate Interval Betwee Onset and Dear	en ith
	Pnysician /Medical		resulting in death)	Jowel					
8	Examiner		Due to (or as a consequence of):						
	1 1 1	je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					<del>.</del>	
	rcuted nd transit	Examine	cause. Enter Underlying Cause juisease c. eijury that initiated events  c.						
8760,	ate be executed thysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):						
687	icate physics the t	dica	d						
Вох (	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	B Ectopic pregnancy			ate of delive	,	
	e deati he atte	sicia	1 Yes 2 No	Other (specify)		N	Month	Day Year	r
P.0	that the de led by the a detached f	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	obacco use cor	ntribute to th	e cause of death	h?
Records,	uires that signed t	d by			1 🗆 🗅	Yes 2⊠No	3 Prob	ably 4 Unkr	nown
000	law requir as been si 2 should	Completed			24a. Was		. Were autor	osy findings avai	ilable
Re	The ate ha	om			autop perfo 1 Yes	rmed?	death?		6 01
Vital	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only o	nne)			
of \	Physic this c	To.	1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat  27. Manner of Death 28a. Date of Injury 28b. Time		ome 5 Resid			)	
on	Ing After fune	tion	27. Manner of Death  1 Natural 2 Natural 2 Natural 2 Natural 2 Natural 3 Pending 2 Accident 28a. Date of Injury (Month, Day Year) Injury 1 Natural	of 28c. Injury at Work? M I 1 ☐ Yes 2 ☐ No	280. Describer	low injury occu	4160		
Division	Attanding or death.  actor: After by the fune	ifica	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specity)	street, factory, office	28f. Location (S City or Tox		nber or Rura	Route Number,	
ā	tal or	Certification:	Building, etc. (Specify)		Oily or Tor				
	Te the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de control on the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occur	, and due to the rred at the time,	cause(s) and n date and place	nanner as sta , and due to	ated. the cause(s)	
	Within Comp	M	29b. Signature and title of certifier Whall M. [	). RES - 000	9	29d. Date sign	08, 0:	Day, Year)	
	JC		30. Name and address of person who completed cause of death (Item 23a) (Typ KHALED HASSAN 5601 Loch Rave	n Blud. Beltimore, 1	70 212	39			
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 8 2005						

			For State Registrar	State of M	Marylan	-	artmen rtificat					Reg. No.	2005	With the second	Α
	Physic /Medi		1. Decedent's Name (First, Middle, La  James C. Russel	1						A	Date of De Month pril	Day 14	Year 2005		
	Examir	ner	4a. Facility Name (If not institution, giver Montgomery Hospi  5. Social Security Number 6. S	ce-Casey	House	ast birthday)	Rock	Town, or Vill	Location of e If Under 2		Date of Bird		Montgo	mery	
	Funeral Director			M 2□F	85	Yrs.	Months		Hours	Min.	(Month, Da ine 2,	y, Year)	Ç	thplace (State or Foreign cuntry) cyland	7
	he Maryland 8a-f show utilised at	ector	10a. State 10b. County  Maryland Montgot	mery	10c. City	, Town or Lo	ville							10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	ath with the 23a or 2	Funeral Director	10e. Street and Number  14304 Myer Terrace	e			10f. Zip		20853				ten of What Co	SA	
5-0036	72 hours after death with the Maryland netural', or Items 23a or 28a-1 show Beal Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1 G Yes 2 [ If Yes, Give Year or Dates	s? ] No		Was Dece f Yes, spe 1  Yes		spanic Orig n, Mexican, Specify:	gin? (Specif , Puerto Rid	y Yes or No an, etc.)		4. Race - Ame Black, Whit Specify: Wh		
21215-0	c * 3	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	College (1-4c	r 5+)	life. I	kind of wo DO NOT u	rk done d se retired)	uring most	of working			nd of Business	·	
Maryland 21	be filed tal Hygi d other event, I	To Be Co	17. Father's Name (First, Middle, Last,  Edward G. Russe			Radio	/Tele				irst, Middle, ibson		Emplo	yed	
	nd 2 sh lith and 27 is rr r traurr		19a. Informant's Name/Relationship ( Merida J. Russel		Wife	19b. Mailir			nd Number	r or Rural R	oute Numbe		Town, State, 2		Ī
altimore,	Pages 1 aunent of Heaunt: If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specification of the control		C	lace of Dispo emetery, crer ct Lin	sition (Nar natory or o	ne of	9)	Date		20c. Loc	ation - City or		
Balti	permit. Pages Department of Important: If i any injury or ence.		21. Signature of Funeral Service Licer	Cele		F 5	. Name ar	d Addres	s of Facility	ins F	uneral	L Hom	e. Inc	g,MD 20901	
	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List on Immediate Cause (Final disease or condition	plications that caus ons cause on each a. Acute M	line.	n. Do not ent	er the mod	le of dying					35%	Approximate Interval Between Onset and Death  2 weeks	
8760,	Certificate be executed ding physician and itse as the burial-fransit	dical Examiner	Sequentially list conditions, Tary, Learn's Charles Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Myelody Chie to (b)	s a consequ splast	ic Sym	ndrom	e						1 year	
P.O. Box 6	the death certific y the attending p ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 12No 9 □ Unknown	23c. If yes, outcon 1 ☐Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal at time of de	death 3	]Ectopic pr ] Other <i>(sp</i>					23	3d. Date of deli Month	ivery Day Year	
	sign sign	by	Part II. Other significant conditions of None	ontributing to death	but not resu	alting in the u	nderlying c	ause give	n in Part I.			obacco us Yes 25	_	the cause of death?	
of Vital Records,	The law ate has by page 2 sh	Completed											24b. Were au prior to death? 1 \( \sum \text{Yes}	topsy findings available completion of cause of 2 No	
ion of Vita	Attending Physicien: Th r death. sctor: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, L	ijury	ER/Outpatien 28b. Time of Injury		8c. Injury Work	r: 4 🗆 Nur	rsing Home 28d	theck only of 5 Resident Resid	dence 6		any)Hospice	
Division	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	286. Place of I	njury - At ho etc. <i>(Specif</i> y	me, farm, str	eet, factory	, office	1215776	28f.	Location (S City or Tow	Street and vn, State)	Number or Ru	iral Route Number,	
	n 24 hours n 24 hours ne Funera	edical (	29a. Certifier (Check only one)  1 🖾 Certifying Ph 2 🗀 Medicel Exam	ysicien: To the be- niner: On the basis and manner	of examinat	wledge, death ion and/or inv	occurred estigation	at the time, in my op	e, date and inion, death	d place, and h occurred a	due to the dat the time, d	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)	
)	To the within to the comp	M	29b. Signature and title of certifier	Sherer	- m.	D	290	D 21					signed (Month		
,	5+1		30. Name and address of person who Peter B. Sherer,							on . MD	2090	•	-1+, ZU		
Ī	Sta Regist		31. Date filed (Month PR 15	2005 32. Jegis	trar's Signat	rrara	rade	,							

# Amended Item 2 per Physician 04/15/2005 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary			of Health ar of Death		Reg.	No. 4005	
	Physici	an	1. Decedent's Name (First, Middle, Las	"Rhoten-	***			Ap	Total 3	Day 2005 Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give		717	4b. City. Toy	wn, or Location of I	Death	111	4c. County of Death	12:30 a <sup>M</sup>
	Examin	er		swall buism			Toneyto			Carro	/
	Funeral		5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Y Months D		Min. (M	ate of Birth fonth, Day, Ye	ar) 9. Birth	place (State or Foreign
-	Director		176-44-0914 Usual Residence of Decedent	X M 2□F	52 Yrs.			Au	gust 8	1952	MD
	show	-	10a. State 10b. County	100	c. City, Town or Lo	ocation					10d. Inside City Limits
	Mary a-f sh	tor	MD Carro	011	Westn	ninster					1 ☐ Yes 2 X No
	or 284	Funeral Director	10e. Street and Number			10f. Zip Co			10g.	Citizen of What Cou	intry?
	ath w	rai	515 S. Frizzellb				21158			USA	
	er de Items	nue	11. Marital Status  1 ☐ Never Married 2 ☐ Married	<ol> <li>Was Decedent Ever Armed Forces?</li> <li>1 ☐ Yes 2 ☒ No</li> </ol>	in U.S. 13.	Was Decedent If Yes, specify	t of Hispanic Origir Cuban, Mexican, F	n? (Specify Y Puerto Rican,	es or No- , etc.)	14. Race - Ameri Black, White	
336	ai', or	by F	3 ☐ Widowed 4 € Divorced	If Yes, Give Year or Dates:		1⊡Yes 2¶∑	No Specify:			Specify: W	nite
215-0036	filed within 72 hours after death with the Maryland Hygiene. that than "natural; or Items 23a or 28a-f show ant, the Madical Examinat must be rediffed at	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual C	occupation done during most o	of working	16b	. Kind of Business/Ir	ndustry
21	Aithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use r	etired)			D1 -1	
d 21	filed w Hygier thar ti		12 17. Father's Name (First, Middle, Last)			Self Em		s Name (First	t, Middle, Maid	Plumber	
and	d be id be tall liked or	To Be	George E. Rhote	n, Jr				·	S. Zeno	,	
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked othar than "Iraumatic evant, the Med	-	19a. Informant's Name/Relationship (7	уре, Print)						ly or Town, State, Zij	
	and 2 Balth a n 27 is		Sandra Bare/sist							nster, MD	21158
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Menial Hygiens. Department of Health and Menial Hygiens important: if item 27 is marked other than "natural; or items 23s or 28s-1 show airy highly or other traumatic event, the Medical Examination into the rediffied at any highly or other traumatic event, the Medical Examination into the rediffied at any force.		20a. Method of Disposition	Removal from State	Ob. Place of Dispo			/15/20	05	Location - City or T	
ij	artmen artmen ortant: injury		<ul><li>4 □ Donation 5 □ Other (Specify</li><li>21. Signature of Funeral Şervice Licen</li></ul>				ist Churc			Jpperco, M	MD .
Ba	permit. Departr importu any inji		1 Mm	1			ddress of Facility uneral H ington R				21157
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the	death. Do not en	ter the mode o	f dying, such as ca	ardiac or resp	iratory arrest,	SUCE , I'M	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		F	neumo	013-				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co							
		<u>-</u>	Sequentially list conditions,	b. Due to (or as a co	nsequence of):						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
oʻ	an and	Еха	resulting in death) Last	Due to (or as a co	nsequence of):						
8760,	iaw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	lical	(	d							
9 XO	leath certifica attending pt ifor use as ti	Physician/Med	IF FEMALE:	23c. If yes, outcome of pr	regnancy					OOM Date of deli-	
Bo	atten atten	clan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ 4 Pregnant at time	Fetal death 3	☐Ectopic pregr ☐ Other (speci				23d. Date of deliv Month	Day Year
0	that the de led by the a detached f	hysi	9 Unknown	9□ Unknown						J	
S, D	w requires that s been signed b should be deta	by P	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	nderlying caus	se given in Part I.	2		o use contribute to t	
ecords,	bluor	ted						_	1 🗌 Yes	2 No 3 Pro	bably 4 □Unknown
ec	has b	Completed						2	4a. Was an autopsy performed	, prior to co	opsy findings available ompletion of cause of
al B	ician: The t certificate ha rector, page		25. Was case referred to medical						☐ Yes 2 🗷		2□ No
Vital	Physician: this certific ral director,	To Be	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3 DOA	Other	of Death (Che		6 □Other (Speci	ifv)
ι of	ding Physician: The the the the this certificate he funeral director, page		27. Mann of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yes	ar) 28b. Time o		Injury at Work?		escribe how in		
Sior	Attanding r death, actor: After by the funer	atlc	2 Accident investigation			М	1 ☐ Yes 2 ☐ No				
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S		reet, factory, or	ffice		ocation (Street ity or Town, St	and Number or Run ate)	al Route Number,
	Hospitai 24 hours a Funaral I tely filled		29a. Certifier 1 Certifying Ph	ysician: To the best of my	y knowledge, deat	h occurred at t	he time, date and	place, and du	ue to the cause	e(s) and manner as s	stated.
	To the Hospital or Attand within 24 hours after death To tha Funaral Diractor: completely filled in by the	Medical	(Check only 2 Medical Exemone)	niner: On the basis of exa and manner stated.	mination and/or in	vestigation, in	my opinion, death	occurred at t	the time, date	and place, and due t	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	In ( Mas )		29c. L	coose number	342		Date signed (Month,	
	NIL			Vin y	MIE		200)	117		trovil 13,	2002
	5		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)	te 307	insetu	inster	MO	21157
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis ar's	Signature	74		- 2)			
	Registi		APR 15	2005	a &	boots					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend item #8 per fh/wichd/ Certificate of Death4-21-05/dls Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician**  $P^{M}$ ELIZABETH MAE PURNELL SMACK 3, April 2005 /Medical 4:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BERLIN NURSING HOME BERLIN WORCESTER Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number **Funeral** Days 93 1 ☐ M 2 ☐ XF Dec. Director 217-03-5942 Dec. 27 1911 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location itam 27 is marked other then "natural", or items 23s or 28a-f show other traumatic event, it is Medical Evarth at must be mailtied at 10d. Inside City Limits 1 ☐ Yes 2 No Director Worcester Maryland Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 Showell Street Funeral JSA 14. Race - American Indian, 21811 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) laborer Shore-Up, INC Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Health and Mental Pages 1 and 2 should be George Robbins Addie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Smack, If itam 27 Joyce Harris Cottman/daughter 110 Showell Street - Berlin, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō injury or 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) St. Paul Ch. Cemetery | 04/20/2005 Berlin, Maryland 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21. Signature/of Funeral Service Licensee Jolley Memorial Chapel 21801 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cus /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical the attending IF FEMALE: use If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe 2 No 1 Tes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ٥ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ursing Home 5 Residence 6 Other (Specify) After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Natural 5 Pending death. 2 🗌 No investigation 1 Tyes 2 Accident Diractor: Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funaral Dira 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Pay, Year) completed cause of death (Item 23a) (Type, Print) ime and address of person o rodelle 10holes 31. Date filed (Month, Day, Year) Pagistrar's Signature APR 1 8 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 115 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** APRIL 17. 2005 Robert Leo Stewart 16:45P <sup>™</sup> /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months 1 **3** M 2 □ F 66 **Director** 219-34-8032 June 2, 1938 Washington, DC Usuel Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location show 10d. Inside City Limits or items 23s or 28a-f shows introduced at 1 ☐ Yes 2 ▼ No Maryland St. Mary's Chaptico Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 36775 Holly Field Lane 20621 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🙀 Marned ☐Yes 2 No Yes, Give 1 ☐ Yes 2X No Specify: Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sheet Metal Worker Union 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill timent of Health and Mental H tant: If Item 27 is marked ott 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis Gram Stewart Alma B. Mueller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Louise Stewart/Wife 36775 Holly Field Lane, Chaptico , Maryland 20621 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery April 21,2005 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A., P. O. Box 270, Leonardtown, Maryland 20650 ichael Neven Hardere 23a. Part1. Enter the disease, or complications that caused the death Po not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ento cu Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** mondry Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a consequent of) Examiner The law requires that the death certificate be executed burial-transit attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Mahner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Natural Pending 2 Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47097 MD

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Vital

of

Division

STEWART

ROBERT

31. Date filed (Month, Day, Year) APR 1 9 2005

30. Name and address of person who completed callise of death (Item 23a) (Type, Print)

DR. MARTIN MCGREIVY ST. MARYS HOSPITAL POST OFFICE BOX 527, LEONARDTOWN, MD 20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 Year **Physician** April 14, William P. Shook 12:10 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Director 577-36-8572 74 June 1, 1930 Washington DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County if item 27 is marked other than "natural; or items 23a or 28e-f show or other treumstic event, the Madical Examinar must be notified at 10d. Inside City Limits 1 √Yes 2 No Montgomery Potomac Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9613 Kentsdale Dr. 20854 USA 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian Black, White, etc. Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4+ Cartographer Federal Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked oth any linjury or other treumatic event, 9DRS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Tyler Shook Pauline Healy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colleen Shook / Spouse 9613 Kentsdale Dr., Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Mt. Comfort Crematory 04/16/2005 Alexandria, VA 21. Signal of uneral Service Licens 22. Name and Address of Facility Joseph Gawlers Sons, INC. M01378 5130 Wisconsin Ave. NW, Washington DC, 20016 1. Enter the disease or compete tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. Approximate Interval Between Onset and Death shock or heart failure Immediate Cause (Final disease or condition resulting in death) **Physician** Stage 4 Recurrent Esophageal Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. Due to (or as a consequence of): by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 😾 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 □ No 1 ☐ Yes 2 🔀 No 1 TYes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 ☐ Yes 2 🔀 No Certification: To 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ★ Other (Specify Hospice 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation in my religion death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and t 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

., 6001 Muncaster Mill Rd., Rockville, MD 20854

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Harrison

S	E. SIM	1ON	2	pe or Print in Black				_	
	D. Dir.	1011	1 - For State Registrar	State of Maryland / D	Department of F Certificate of I			iene 2005	14715
	Physici	00	1. Decedent's Name (First, Middle, Last)			2	2. Date of Deat Month	h Day Year	3. Time of Death
	Physici /Medio			ONS			APRIL	16, 2005	1030 Ам
	Examin	ier	4a. Facility Name (If not institution, give st 4318 LAWRENCE STRE		4b. City, Town, or HYATTS	r Location of Death VILLE		PRINCE GE	
	Funeral Director		242-70-6872	7. Age (In yrs. last birt	hday) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min. M	Date of Birth (Month, Day, ay 25,	9. Birth 1944 Vil	place (State or Foreign htry) ginia
	tryland show	_	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Ba-f	octo	MD Prince Geo	orge's Colmar					1 <b>X</b> Yes 2 □ No
	Vith th	Director	10e. Street and Number		10f. Zip Code		10	og. Citizen of What Cou	ntry?
	s 23	eral	4318 Lawrence Stre		207		7 . V N	USA	and lading
2	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is merked other than "natural," or items 23e or 28e-f show other traumatic avent, the Medical Examinal must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Amed Forces?  1	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2XXNo	ispanic Origin? (Specian, Mexican, Puerto Ri Specify:	fy Yes of No- can, etc.)	14. Race - Ameri Black, White, Specify:	etc.
3	tura atura		15. Decedent's Educa	ation 16a.	Decedent's Usual Occup	ation		W Indicate Windows Win	nite
2	hin 72 an "na Media	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired	during most of working f)	7		,
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2	Men Men Marke Marke	ျ	Green Columbus Sin			Leda Wad			
<u> </u>	12 sh hand 7 Ism maum		19a. Informant's Name/Relationship (Type		Mailing Address (Street				
ב ט	1 and Healtl Bm 2 ther 1		Judy A. Simons, S <sub>1</sub> 20a. Method of Disposition		18 Lawrence			20c. Location - City or To	20722
2	Pages nent of I int: If it		1 ☐ Burial 2 X Cremation 3 ☐ Re	novar ironi State	Disposition (Name of y, crematory or other place	1			
			*4 ☐ Donation 5 ☐ Other (Specify)  21. Sign wife of Fineral Service Censes		itan Crematory	7 4/20/2	2005 A	lexandria, meral Home,	Virginia
0	permit. Departr Imports any inj			5 Mars 42				ierai Home, itsville, Ma	
	انحه		23a. Part1. Enter the disease, or complic	ations that caused the death. Do n					Approximate
	Grandales.		shock, or heart failure. List only one Immediate Cause (Final	A 1.1		22015:10		-	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of		ARDIOVA			
	Examiner						U	SEATE	
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מו ש	ding Physician: The law h. After this certificate has b funeral director, page 2 s	Completed					autopsy perform 12 Yes 2	prior to co death? No 1-XYes	mpletion of cause of
VII de	sicia certi irecto	o Be	25. Was case referred to medical examiner?  1 ★ Yes 2 □ No	spital:	other actions of	26. Place of Death (			. AT COUNTR
5	Phy ar this aral d	H	27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Out 28a. Date of Injury 28b. T	ime of 28c. Injury	at 28		nce 6 XOther (Specif winjury occurred	y) AI SCENE
5	nding ath. r: Afte e fun	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Ir	njury Worl M 1 ☐ `	<br Yes 2 □ No			
SIND	To the Hospitel or Attending Physician: The law requires that the death certificate be within 24 hours after death. After this certificate has been signed by the attending physicial to the Lunarel Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28	f. Location (Str City or Town,	eet and Number or Rura State)	al Route Number,
	te Hospit 24 hours te Funare letely fille	Medical (	29a. Certifier (Check only one) 1 ☐ Certifying Physic 2X Medical Examine	cian: To the best of my knowledge or: On the basis of examination and and manner stated.	, death occurred at the tim For investigation, in my op	ne, date and place, and pinion, death occurred	d due to the ca at the time, da	use(s) and manner as s te and place, and due to	tated. o the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License	e number	29	d. Date signed (Month,	
			I une 22	-	OCME			APRIL 17,	2005

State Registrar

DHMH 17 Rev 1/2001

111 Penn Street

Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RUBIO, HD

32. Registrar's Signature

ANA
31 Date filed (Month Day Year)
APR 1 8 2005

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		For		State of	f Maryla	and / [	Depai	rtment	of H	ealth a	and M	1ental F	lygie	ene			
	•	<ul> <li>State</li> <li>Registrar</li> </ul>					Cert	tificate	of L	Death			Reg	. No.:	(3) pm		
		1. Decedent's Name	e (First, Middl	e, Last)								2. Date of	Death	60	UJ	3. Timle	of Death
Physicia /Medica		MORE	RIS	LEON	SILVE	RMAN						APRIL	. 13	Day 200	5 Year	7:	35A <sup>™</sup>
Examine	r	4a. Facility Name (/	f not institution	n, give street and nur	nber)			4b. City, To	wn, or	Location	of Death			4c. Count	y of Death		
		MARINER	R HEALT	H OF SILV	ER SPR	ING		SIL	VER	SPR	ING			MONT	GOMER'	Y	
Funeral		5. Social Security N	lumber	6. Sex	7. Age (In y	rs. last bir	thday)	If Under 1		If Under		8. Date of	Birth	(00 m)	9. Birthp	lace (State	or Foreign
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Marical Examinar must be notified at once.	o De	17. Father's Name	(First, Middle, EPH SIL									e (First, Mide KRASNI		niden Sumai	те)		
should had a		19a. Informant's Na	ame/Relations	hip (Type, Print)		19b	. Mailing	Address (S	Street a	nd Numbe	er or Rura	al Route Nui	nber, (	City or Town	. State. Zip	Code)	
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Page:		1 St Burial 2	☐ Cremation 5 ☐ Other (S	3X Removal from ( pecify)	State KI			MEM.		· 1	04/1	17/05	F	ALLS	CHURCI	H, VI	RGINIA
permit. Pa Departmer important: any injury once.		21. Signature of Fu	ineral Service	Licensee			22. ED	Name and A	Addres SAG	s of Facilit	NED!	ұ∟ рдд	EGT	ION.	MC <sup>508</sup>	250	

**Physician** /Medical

Baltimore, Maryland 21215-0036

Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed page 2 should be detached for use as the burial-transit Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, within 24 hours after To the Funeral Direct

Division of Vital Records, P.O. Box 68760,

resulting in death)
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

9 🗌 Unknown

3 🗀 Suicide

IF FEMALE:

Immediate Cause (Final

	h	
,	0. —	Due to (or as a consequence of):
	C	Due to (or as a consequence of):
L	d	
T		

PNEUMONIA

Due to (or as a consequence of):

23c.	If yes, outcome of pregnancy
	1 Live birth 2 Fetal death
	4 Pregnant at time of death
	9 Unknown

3 ☐Ectopic pregnancy 5 ☐ Other (specify)

	23d. Date of de	eliver
ctopic pregnancy Other (specify)	Month	(

Part II.	Other significan	t conditions	contributing to de	eath but not	resulting in the	underlying o	cause given in	Part I
	SEVERE	DEMENT	ľΤΛ					

SEVERE DEMENT	IA				1 L Yes
					24a. Was an autopsy performed?
5. Was case referred to medical				26. Place of Death (0	Check only one)
examiner?	Hospital:	2 TER/Outpationt	3 \( \text{DOA} \)	Other: 4X Nursing Home	E C Decidence

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

											1 ☐ Yes	2 N	) 1	Yes	2
25. Was case referred to medical examiner?			26. Place of Death (Check only one)												
	1 Yes 2 No	Ho	spital: 1 🗀 Inpatient	2 🗀	ER/Outpatient	3 🗆 [	AOC	Other: 4	Nursing H	ome	5 🗌 Res	idence	6 🗀 Other	(Speci	fy)
27	. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	28a. Date of Injury (Month, Day Ye	ar)	28b. Time of Injury	М	28c.	Injury at Work? 1 ☐ Yes	2 🗀 No	28d	Describe	how inju	ry occurred	-	

3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
29a. Certifier (Check only one)	1 Certifying Physi 2 Medical Examine	cian: To the best of my knowledge, death occurred at the term on the basis of examination and/or investigation, in my and manner stated

6 Could not be determined

1 Certifying Physic	an: To the best of	f my knowledge, death acc	urred at the time, date and place, and due to th	A Causa(s) and manner as stated
2 Medical Examiner	: On the basis of	examination and/or investig	pation, in my opinion, death occurred at the time	e, date and place, and due to the cause(s)
	and manner stat	ed.	paration, dog and dog at the time	o, sale and place, and due to the oddoo(s)
itle of certifier		/	29c. License number	29d. Date signed (Month, Day, Year)

D09874

/	and mariner stated.	
29b. Signature and title of confifier		29c. l
124	Koresto	

29d. Date signed (Month, Day, Year) APRIL 14, 2005

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

3 Probably

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2 💢 No

Approximate Interval Between Onset and Death 2 WEEKS

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3720 FARRAGUT AVE. KENSINGTON, MD 20895-2110 BARRY N. ROSENBAUM, MD 31. Date filed (Month Day Year) APR 1 5 Registrar's Signature 2005

State Registrar

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12, April 2005 Robert Fischer Stohlman 1:15 A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Director 557-10-2784 90 Sept. 10,1914 Ohio Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or guhar traumetic event, the Medical Examinar must be invitibled at apneas. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland | Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17709 Queen Elizabeth Drive USA Funeral 20832 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 yes 2 No 1941− If Yes, Give Year or Dates: 1966 1 Never Married 2K Married 1 ☐ Yes 2 ☒ No δ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Major U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Karl Henry Stohlman Laura C. Fischer 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmen M. Stohlman/Wife 17709 Queen Elizabeth Drive, Olney, Maryland 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 7/7/2005 | Arlington, Virginia 22. Name and Address of Facility DeVol Funeral Home 21 Signature of Funeral Sorvice License NO East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to or as a con-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 Tes 2 ER/Outpatient 3□ DOA 27. Manny of Death 1 Matural funeral 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No death 2 Accident the Director: 3 🗍 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number of death (Item 23a) (Type, Print) 30. Name and address of pers 31. Date filed (Month, Day, Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

2005

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Amended Item 10f per F.D. 04/15/2005 Carroll County, wil Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Zoo Year Physician 4:24 PM mon narew SCKSON 111 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death [ SYRDI] 16/1950 westmins ente ( arroll If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea 4 / 8 / 1 9 2 4 5. Social Security Number 6 Sax 9. Birthplace (State or Foreign **Funeral** Days 1XM 2□F 229-16-9366 81 MARYLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ehow the Madical Examiner wast be notified at 1 ☐ Yes 2X No MD. CARROLL WESTMINSTER Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? <del>21157</del> 21158 permit. Pages 1 and 2 should be flied within 72 hours efter deeth v Department of Heelith and Mental Hygiene Importent: If item 27 is marked other than "natural", or items 23a any njury or other treumatic event, the Modical Examinar reservents. 154 ROCKLAND RD. USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REAL ESTATE BROKER SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) REV. CLARENCE HADDON SHAW MARY GENEVA JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 154 ROCKLAND RD., WESTMINSTER, MD. 21158 JANE SHAW - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition A Removal from State ST. 1 XBurial 2 Cremation JAMES CEMETERY 4/16/05 NEW WINDSOR, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Pm.1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or having failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Juse (Final **Physician** remiz disease or condition resulting in death) 237 /Medical Due to (or as a consequence of): Examiner CongRSH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OPSTRUCTUR 100 mons 1 Yes 2 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 😢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The law requires that the death certificate be executed attending physicien and for use as the burial-transit Division of Vital Records, P.O. Box 68760, been signed by the a should be detached t page 2 s Hospital or Attending Physicien: funeral director After efter death. the filled in by To the Hospital of within 24 hours ell to the Funerel Dicompletely filled i

with the Maryland

Baltimore, Maryland 21215-0036

(Check only 29b. Signature and title of certifier

29c. License number

100059943

29d. Date signed (Month, Day, Year)

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

295

John . Ansel MO 31. Date filed (Month, Day, Year)

32. Regionar's Signature

Registrar

APR 1 5 2005

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Stener Ave.

		1	State of Maryland / Department of Health a  1- State Registrer  Certificate of Death		-	ne	5 11.710
			Decedent's Name (First, Middle, Last)		Date of Death		3. Time of Death
ı	Physicia /Medic		JEAN LARUE STONESIFER	1.4		Day Year	
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of			4c. County of De	
			UNION MEMORIAL HOSPITAL BALTIMORE	E		CITY	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1 If Under 2 Yrs.  216-48-4786 1 M 2XIF 62 Yrs.  Usual Residence of Decedent	Min. (/	Date of Birth Month, Day, Ye 9 / 1 9 4	9. B 3 MA	irthplace (State or Foreign Country) RYLAND
	land ow		10a. State 10b. County 10c. City, Town or Location			· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
	Mary -f sh	to	MD CARROLL NEW WINDSOR				1 ☐ Yes 2 No
	r 288	irec	10e. Street and Number 10f. Zip Code		10g.	Citizen of What C	Country?
	h wit	a D	405 S. SPRINGDALE RD. 21776		1	USA	
21215-0036	hours after death with the Maryland tural', or Items 23a or 28a-f show al Exartinet Inual be inclifted at	by Funeral Director	11. Marital Status  1 ☐ Never Married  2 ☐ Marned  1 ☐ Never Married  2 ☐ Marned  1 ☐ Never Married  2 ☐ Marned  1 ☐ Yes 2 ☐ No  If Yes, Give Year or Dates:  1 ☐ Yes 2 ☐ No  Specify:	gin? (Specify , Puerto Ricar	Yes or No- n, etc.)	14. Race - An Black, Wh Specify:	
Ş	n 72 hou "nature	ted	15. Decedent's Education 16a. Decedent's Usual Occupation		16b	. Kind of Busines	
212	within 72 ene. than "nai	pie	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most life. DO NOT use retired)	of working			,
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	be filed tal Hygi d other event, I	Bec			st, Middle, Maid	•	
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Maryland	d 2 should th and Mer 7 Is marke traumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number			-	
	5 = 0 =		EARL E. STONESIFER-HUSBAND 405 S. SPRINGDAL	E RD.	,NEW T	WINDSOR	, MD.21776
altimore,			20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	200	. Location - City o	r Town, State
Ĕ	Pages nent of ent: If it ury or o		1 ☑ Burial 2 □ Cremation 3 □ Removal from State  1 ☑ Donation 5 □ Other (Specify)  1 ☑ Donation 5 □ Other (Specify)	EM.4/	15/05	WESTMI!	NSTER, MD.
Balt	permit. Pages Department of Importent: If it any injury or once.		21. Signature 3 - unarral lettine Licensee 22. Name and Address of Facility 254 E. MAIN ST	FLET	CHER F	UNERAL	HOME
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as c shock, or heart failure. List only one cause on each line.	cardiac or res	piratory arrest,		Approximate Interval Between
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	/Medical		resulting in death)  Due to (or as a consequence of):				The state of the s
	Examiner		Sequentially list conditions b.				
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Ž	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:				
ROX	ath contract	ian/	23b. Was decedent pregnant in the past 12 months?			23d. Date of d	elivery Day Year
	at the dea by the a tached f	/sic	1 ☐ Yes 2 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown			NOTAL	Day Toal
<u>.</u>	d by	Ph	· · · · · · · · · · · · · · · · · · ·	T	22a Did tabaa		and the annual of dente 2
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ecords,	v require been sig should b	ted		_	1 ☐ Yes	2 No 3 □ F	Probably 4 □Unknown
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<b>X</b>		Co		;	performed Yes 2 🗆		
Vital	Physician: Th this certificate al director, pag	Be	examiner?	of Death (Ch	eck only one)		**
ot	Physi this c	P		rsing Home	5 Residence	6 ☐Other (Sp	ecify)
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Division	or Att	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		ocation (Street City or Town, St		Rural Route Number,
	urs a						
	To the Hospitel or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and control of the basis of examination and/or investigation, in my opinion, death and manner stated.	h occurred at	the time, date	and place, and di	e to the cause(s)
	To To Con	~	29b. Signature and title of certifier  29c. License number	P-182	4 4 29d.	Date signed (Mor	ntn, Uay, Year)
	MJLH		1. Inkor 14. V. H1 24386	246	A	25/1/12	, 2005
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Vladimir A. Sinkor 4108 Roland Av	enu	ce B	altima	e MD 21211
	Sta Registr		29b. Signature and title of certifier  29c. License number  AT 2438 6  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Vadimir A. Sinkor 4108 Roland Av  31. Date filed (Month, Day, Year)  32. Registar's Signature  APR 1 5 2005				
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ROY LEE SPIVEY 10, APRIL 2005 11:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL HOSPITAL CENTER WESTMINSTER CARROLL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 ☐ F 60 Yrs Director 219-42-7491 8/31/1944 VIRGINIA Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad other then "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at MD CARROLL WESTMINSTER Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 WARD AVE. 21157 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 2 should be filad within 72 hours after on and Mental Hygiana.

Is marked other then "natural", or ite. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LABORER CONSTRUCTION 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **EDWARD** SPIVEY SALLIE MAY MORRISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 sof Haalth an BETTY L. SELL - SISTER 190 OLD CARLISLE RD., BIGLERVILLE, PA.17307 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State permit. Pagas 1
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important: If ital
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State COUNTY CREMATION 4/12/05 SYKESVILLE, MD. \* 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death **Physician** nronce 10415 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Alagios county Frex To NE lok Ja (ME Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Examiner cartificate be executed as the burial-transit Due to (or as a consequence of): attanding physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) tha 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cartificata has autopsy performed? 1 Yes 1 Yes 2 🗆 No Hospital or Attanding Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA Hopatient this 27. Manner of Death Date of Injury (Month, Day Year) Aftar t Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after daath. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To tha Funarai D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MIL 34298 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Kass 410 Malcolm Drive Ste C Westminster MD 10 31. Date filed (Month, Day, Year) 32. Regerar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Apr. Pay Dolores Joan Sherwood 2005 7:45 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 476 Edinburgh Court Anne Arundel Severna Park If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jul. 2, 19 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Days 59 Yrs. Director 216-42-6649 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28a-1 show eny injury or other treumatic event item. 10a State 10d. Inside City Limits 10h County 10c. City, Town or Location MD Anne Arundel Director Severna Park 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 476 Edinburgh Court 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⑤ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married White 1 ☐ Yes 2 X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade com 16b. Kind of Business/Industry grade completed) (Give kind of work done du life. DO NOT use retired) during most of working Old Mill Teacher Elementary/Secondary (0-12) College (1-4or 5+) High School Special Ed Department Chair 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Pascal Delores Depper 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Sherwood/Husband 476 Edinburgh Court, Severna Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Apr. 16, 2005 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory ` 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death midiate Lause (Final BREAST **Physician** METASTATIC 25 MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 21 No certificate 2□ No 1 Yes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation ☐ Accident after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of

WOUT

ANTONIO

strar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

HOPKINS O

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

		1 Decedents Name (First Middle Leaving)			Certificate of		R	eg. No. 2	05	11,72
Physici /Media		1. Decedent's Name (First, Middle, Last Carleton	Edward	S	Shearer		2. Date of Deed Month April 1	0 , Dey 2005	Year	3. Time of beath 8:00 am
Examir		4a Fecility Neme (If not institution, give Genesis Elder Car		Creek		4b. City, Town, or L Annapolis		4c. County of		del :
Funeral Director		5/9-34-1910	X 7. Age DM 2□F	(In yrs. last bir	thdey) If Under 1 Yea Months Days		8. Date of Birth (Month, Day, NOV • 25 ,	Year) 1927	9. Birthpli Count Penn	<sup>ace (State or Fore</sup> ry) sylvania
arylend ahow	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow					10	d. Inside City Limi
with tha M Se or 28s-f	i Director	MD Anne Arun  10e. Street and Number  908 Mount Airy Roa		Davids	onville 10f. Zip Code 21035			og. Citizen of W		
filed within 72 hours after death with the Marylend Hygiena. ther than "natural", or flame 23a or 28a-f ahow ent, the Medical Examiner must be notified at	Completed by Funeral	11. Marital Status  1 \( \overline{\Omega} \) Never Married  2 \( \overline{\Omega} \) Married  3 \( \overline{\Omega} \) Widowed  4 \( \overline{\Omega} \) Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	ever in U,S.	13. Was Decedent of If Yes, specify Cu			14. Race	- America	ın Indian,
filed within 72 ho Hygiena. other than "natura ent, ine Medical I	ompieted	15. Decedent's Edu (Specify only highest gred Elementary/Secondary (0-12)	cetion le completed) College (1-4or 5-	16a. +)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire Repair	ipation a during most of work ad)	king	16b. Kind of Bus		ustry
	To Be C	17. Fether's Neme (First, Middle, Lest)  Joseph Bosler Shea	ror			18. Mother's Nam			•	
12 should be h and Mantal is marked o raumatic eve	T.	19a. Informant's Name/Relationship (7) Monique Bommelje-I	vpe, Print)		. Mailing Address (Stree		ral Route Number	City or Town, S	State, Zip (	
permit. Pegas 1 and 2 Department of Haalth Important: If Item 27 i any injury or other tra once.		20a. Method of Disposition  1 Burial 2 Micremation 3 F  4 Donation 5 Other (Specify)  2 Supering at Furieral Service Licens		Metrop	i Disposition (Name of ry, crematory or other pl colitan Crer 22. Name and Addr 22 42 Hudson S	ess of Facility Ad	april 4,2005 <sup>P</sup> vent Funer		ria, v ation	VA Services,
Chicate be executed  'Medical Examiner as the burial-transit as the burial-transit	edicai Examiner	23a. Part1. Enter the disease, or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Cere	Due to (or as a c	consequence of):			2	, 1	Approximate niterval Between Onset and Death
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s been s	Completed by						24a. Was ar perform	n autopsy ned?	avai com	e autopsy finding lable prior to pletion of cause eeth?
certifica rector,	o Be Co	25. Was case referred to medical examiner?	lospital:			26. Place of Deat		в)		Yes 2□ No
Aftar fune	<b>⊢</b> ∤	27. Manner of Deeth  1 Deeth  2 Deeth  2 Decident  5 Pending investigation	1 ☐ Inpatier  28a. Date of Injury (Month, Day	/ 28b. T	Time of 28c. Injury	Nursing Ho	me 5 ☐ Reside 28d. Describe ho			
frer in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc.	(Specify)	rm, street, factory, office		28f. Location (Sti City or Town	, State)		
ne Hospital in 24 hours a he Funeral C pletaly filled	edicai	29a. Certifier Check only one) Certifying Physical Examination	sician: To the best of ner: On the basis of and manner stat	examination and	, death occurred at the t d/or investigation, in my	ime, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and man ite and place, ar	ner as sta nd due to t	ted. he cause(s)
To the company of the	Σ	29b. Signature and hite of certifier	7			se number		Od. Date signed		
Sta Registr	ite	30. Name and address of person who con ADITYA CHOPK 31. Dete filed (Month, Day, Year)  APR 13 20	PA. M.D. 32. Jegistrai	600 Ric	Type, Print) Hopely Ave. Suit	ce 231 Annap	olis, Mary	land 2140	1	

DHMH 16 Rev 6/95

		1 - For Stata Registrar	State of Mary		artment of F rtificate of		ntal Hygien Rag. N	13 13 13 mm	11.72
Physici /Medic	cal	1. Decedent's Name (First, Middle, La  Donna M. Smith				A	oril 10,		3. Time of Death 3:35 P
Examin Funeral	ner	4a. Facility Name (If not institution, giv  Larkin Chase Nur:  5. Social Security Number 6. S	sing Home	yrs. last birthday)	Bowie If Under 1 Year	If Under 24 Hrs. 8.	P:	rince Geor	ges ace (State or Forei
Director		579-50-3920  Usual Residence of Deceden  10a. State 10b. County		66 Yrs.	Months Days	Hours Min. 10	(Month, Day, Yea )/05/1938	Kenti	icky  Od. Inside City Lim
Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23s or 28s-f show any figury or other traumatic event, the Medical Extrainer must be notified at once.	irector	Maryland Prince (		owie	10f. Zip Code		10g. C	Cilizen of Whal Coun	1 May Yes 2 □ I
ems 23a o ar must be	Funeral Director	12511 Kilbourne :	Lane 12. Was Decedent Ever	in U.S. 13.	20715	dispanic Origin? (Specify an, Mexican, Puerto Ric	Ves or No-	A 14. Race - Americ Black, White,	
turat', or it	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: Whit	e
giene. er than "na it e Medic	Completed	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12)	College (1-4or 5+)	Home 1	kind of work done DO NOT use retire	nation during most of working d)		Kind of Business/Ind	ustry
and Mental Hygiene. Is marked other then " sumatic event, it e Max	To Be C	17. Father's Name (First, Middle, Last, James Harlan Moor	re, Sr.			18. Mother's Name (F		en Sumame)	
tealth and sm 27 Is m ther traum		19a. Informant's Name/Relationship ( Colleen Neutzling  20a. Method of Disposition	/ Daughter	2709	Bains Co	and Number or Rural Report Crofton	n, MD 21	114	
artment of h ortant: If ite njury or of		1 Burial 2 Cremation 3 C  4 Donation 5 Other (Specif	y)	Ob. Place of Dispo cemetery, crer Huntt Cre	ematory	4/13/2	005 Wa	Location - City or To	
Departr Imports any Inji		23a. Part1. Enter the disease, or com	7	16	5000 Anna	ess of Facility Rober  Apolis Road	Bowie, 1		Approximate
iysician Medical kaminer	er	snock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	nsequence of):	OF TH				Interval Between Onset and Death
physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leauning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a co	nsequence of):					
by the attending ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pi 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of delive Month	ry Day Year
been sign	þ	Part II. Other significant conditions of OIABETES	meuro		nderlying cause gr		1 🗆 Yes	use contribute to th	e cause of death?
ate has page 2	e Completed	25. Was case referred to medical					24a. Was an autopsy performed?	prior to con death?	sy findings availand the state of the state
this cert at directo	To Be	examiner?  1 Yes 2 No	Hospital: 1   Inpatient	2 ER/Outpatier	it 3 DOA Ot	26. Place of Death (Coner. 4 Nursing Home		6 ☐Other (Specify	)
After funer	Certification:	27. Manner of Death  1 Alatural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be			M 1	yat 28d rk? Yes 2 □ No	. Describe how in	jury occurred	
i after (		4 Homicide determined	building, elc. (S	pecify) y knowledge, deati	occurred at the til	me, date and place, and	City or Town, Sta	(s) and manner as st	ated.
nera / fille	10	(Check only 2 Madical Example 1997)	niner: On the basis of eva	mination and/or in	vestigation in my	pinion death occurred	at the time, date a	nd place, and due to	the eques(s)
within 24 hours after death  To the Funeral Director: completely filled in by the	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens			Date signed (Month, L	

State Registrar 31. Date filed (Month, Day, Year)

MUSA MOMOH MO Registrar's Signature

_			State of Maryland / Departme	ent of Health and Mental Hate of Death	
	Physic /Med Exami	ical ner	Avnold John Timko  4a. Facility Name (If not institution, give street and number)  1659 Gemini Drive Syk	ty, Town, or Location of Death	Death Day Year 3. Time of Death 1.2 2025 // 21 AM  4c. County of Death Carroll
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un Monti Usual Residence of Decedent		Birth Place (State or Foreign Country) PA  9. Birthplace (State or Foreign Country) PA
	th the Maryland or 28a-f show	Director	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	e Zip Code	10d. Inside City Limits  1 □ Yes 2 □ No  10g. Citizen of What Country?
d 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Ffeath and Mental Hygiene. I feath and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Martical Examiner must be indifficial at	e Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)	work done during most of working use retired) ic technician	Specify: white  16b. Kind of Business/Industry  Northrop Grumman
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Me	To Be	John P. Timko  19a. Informant's Name/Relationship (Type Print)  10b. Mailing Address	18. Mother's Name (First, Middle Anna Yarina ss (Street and Number or Rural Route Numb	
Baltimore, Ma	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai		Catherine Timko (spouse)  20a. Method of Disposition  1 Dispositio	ini Dr., Sykesville,	Md 21784  20c. Location - City or Town, State  Sykesville, Md  Deral Home & Chanel
8760,	death certificate be executed  Medical	dicai Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the m shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	, ,	Approximate Interval Between Onset and Death
.O. Box 6	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death 3   Ectopic   4   Pregnant at time of death 5   Other (state of the content of the conten		23d. Date of delivery  Month Day Year
<u>Q</u>	sign d be		Part II. Other significant conditions contributing to death but not resulting in the underlying		robacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Wunknown
Vital Records,	The law ate has b page 2 s	Completed by	Hyperlipelemin	24a. Was auto perfo 1 □ Yes	
Division of Vil	Attending Physician: In death.  Cotor: After this certifice by the funeral director, I	ToB	2 Accident investigation M		
Divi	To the Hospital or Attending Phymitin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	al Certifik	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, facto building, etc. (Specify) 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation	City or Tov	
		Medical	29b. Signature and title of certifier	c. License number	cause(s) and manner as stated, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
	M2		30. Name and addless of per on who completed cause of death (Item 23a) (Type, Print)  What S S May + My 700	28236 ×	April 12, 2005
	Sta Registr		31. Date filed (Month, Day, Year)  APR 1 4 2005  32. Registar's Signature	Es compensation to	2411 110 2120

			1 - For State Registrar	State of Maryland / Dep		lental Hygie	ene	
			Registrar  1. Decedent's Name (First, Middle, La		Tuncale of Dealit	2. Date of Death	J. No. 2005	-11.724
	Physici	an				Month	12 2005	3. Time of Death
	/Medic	cal	Anna E. Terenial			April		3:00 A M
	Examin	ner	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	- 3 - 3
			549 Choptank Co		Annapolis  If Under 1 Year   If Under 24 Hrs.		Anne Aru	
	Funeral Director		5. Social Security Number 140–28–6638  Usual Residence of Decedent	For Age (In yrs. last birthday, 69 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, ) March 14	9. Birth Cou 4, 1936 Pe	olace (State or Foreign ontry) ennsylvania
and	<b>₩</b>		10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
ле Магу	8e-f sh	ector	Maryland Anne A	rundel	Annapolis			1 ☐ Yes XXNo
within 72 hours after death with the Maryland	23a or 2 ast ben	Funeral Director	10e. Street and Number 549 Choptank Cove	e Court	10f. Zip Code 21 401	100	g. Citizen of What Cou U.S.A.	ntry?
dea	8 E	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	
irs after	if, or its	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	nicari, etc.)	Black, White, Specify:	White
d within 72 hours aft	"neture	Completed	15. Decedent's E (Specify only highest gr	ducation 16a. Dece	edent's Usual Occupation be kind of work done during most of work	ing 16	3b. Kind of Business/Ir	dustry
within	than	m	Elementary/Secondary (0-12)	College (1-4or 5+)	Supervisor		Computer	Operations
M .	The T		17. Father's Name (First, Middle, Last	1		e (First, Middle, Ma		Operacions
Viaryiano d 2 should be file	of Health and Mental Hygiene. Item 27 is marked other than "netural", or Itams 23a or 28e-f show other treumstic event. The M. dical Examinar must be notified at	To Be	William N. Bodk	in	Anna J.	McMuller	n	
ind 2 sh	alth and 27 Is m er treum	1 9	19a. Informant's Name/Relationship (William Terenia)		ing Address <i>(Street and Number or Rur</i> Choptank Cove Cour		City or Town, State, Zip Olis, Mary	
Dallimore, Dermit. Pages 1 a	Department of Health a Important: If Item 27 Is any injury or other tre once.		20a. Method of Disposition 1	Tremoval from State	matory or other place)		Oc. Location - City or To	
i: P.	rtant rtant njury		* 4 □ Donation 5 □ Other (Speci 21. Signature of Funeral Service Lice		<del>-</del> ,		rownsville,	_
De m	Depa Impo any ir		21. Signature de Circo Circo	7 ////.	2. Name and Address of Facility Jo 47 Duke of Clouces	The Company of the Co		
-			23a Part 1 Enter the disease or com					Approximate
	ysician Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		Brain tumo	R Respiratory arres	it,	Interval Between Onset and Death
	aminer		Sequentially list conditions,	Due to (or as a consequence of):				
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ate be ex	physicier the buri	cai	· ·	d		-		
X DO	ding p	/Me	IF FEMALE:	23c. If yes, outcome of pregnancy				
I RECOIDS, P.O. BOX 08/00, The law requires that the death certificate be executed	the	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live birth 2 Fetal death 3 [	□Ectopic pregnancy □ Other (specify)		23d. Date of deliver	ery Day Year
Γ į į	ed by detac		Part II. Other significant conditions	contributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
oruza equires	been signed should be det	ted by				1 ☐ Yes	2 No 3 □ Prot	pably 4 Unknown
RECORDS,	2 5	Completed				24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of
= = =	certificate rector, pag				······································	1□ Yes 2	No 1 ☐ Yes	2□ No
VICAL sicien: T	certif ecto	Be	25. Was case referred to medical examiner?	Hospital:	Othor	(Check only one)		
9 g	r this sral dir	To To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury 28b. Time of		me 5 lesiden 28d. Describe how	ce 6 Other (Specification)	(y)
ding of	h. After funer	tlon	1 Natural 5 Pending	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	204. 0000/100 /104	injury occurred	
UNIVISION or Attending	after death. Director: A I in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	00 Place of Injury At home form of		28f. Location (Stre City or Town,	et and Number or Rura State)	Il Route Number,
DIVISION To the Hospitel or Attending	within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page		(Check only 2 Medical Exa	nysician: To the best of my knowledge, dear miner: On the basis of examination and/or in	th occurred at the time, date and place,	and due to the cau	se(s) and manner as s	tated.
the	the I	Medical	0110)	and manner stated.				
To	To cor	4	29b. Signature and title of dertifier	will un	29c. License number 0/9838		I. Date signed (Month, $4/12/20$ )	
			30. Name and addr s of person who	completed cause of death (Item 23a) (Type.	Print) Restra	se Rd.	4/12/201 Aunupol	is, Wed.
4	Sta Registr		31. Date filed (Month, Day, Year)  APR 14	32. Polistrar's Signature	Snorth o			

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend item #19a PER INF G84468711144185011110 eath Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Chrystal April 20, 2005 Thompson 1432 /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F 67 **Director** 218-34-3889 Aug. 16,1937 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or Iteme 23a or 28e-f show It e Modical Examiner must be notified at Director 1 Yes 2 □ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 703 W. Baltimore St. 21740 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race · American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White led 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet nd Mental Hygiene. marked other than Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be fill Health and Mental H Iem 27 is marked oth Be Aaron W. Kesecker Kathleen E. Sheppard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy A. Morningstar/Daughter item 27 i 720 Oak Hill Ave., Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department o Importent: If any Injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 4/25/2005 Hagerstown, MD 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee S-Marth Sir 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part1. Enter the disease, or complice to shock, or heart failure. List only one ca to ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Disseminated Intravascular Coagulopathy Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Retroperitoneal Hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Segmental Artery Transsection L 4 that initiated events resulting in death) Last Due to (or as a consequence of): attending physiclan for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year P.O. I 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗓 No signed by the a the 9 Unknown 9 П Uлклоwn ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Osteoporosos 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2**√** № 25. Was case referred to medical examiner?
1 

Yes 2 □ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P Il Director: After this od in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 5 Pending investigation 1 Natural death. Apr. 19,2005 1 ☐ Yes 2 ☑ No 2 X Accident Unk. While undergoing Surgery 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide ö Washington County Hospital within 24 hours a Hagerstown, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO-1062 17 April 22, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edward W. Ditto, III M.D. 19011 Orchid Terrace Rd. Hagerstown, MD 31. Date filed (Month, Day, Year) Registrar's Signature State APR 2 9 2005 Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Ma	•	oepaπme <i>Certifica</i>			,	giene Reg. No.2	105	11.727
I			1. Decedent's Name (First, Middle, La	ast)					2. Date of De Month	ath Day	V 3	3. Time of Death
	Physici /Medi		Michael	Anastasios	V	ergos				20, 200	Year )5 1	0:30 a.m.
100	Examir		4a Facility Name (If not institution, gir	ve street end number)			4	4b. City, Town, or	Location of Death			o.oc army
1			St. Mary's Ho	ospital				Leonard	town	St.	Mary's	
	Funeral				(In yrs. last bin	Months	er 1 Year Days	If Under 24 Hrs Hours Min	8. Date of Bir	th v. Year)		e (State or Foreign
	Director		4/8-44-0301	HOLM 2LIF	65	Yrs.			Aug. 7,		Iowa	
	pu s		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					104	In side Oits I to b
	aryle sho	'n			roc. Oity, row	TOT EGGZIIGH					-	Inside City Limits 1 ☐ Yes 2 🛣 No
	he N	Director		Mary's				rdtown				
	Nith of the	٦	10e. Street end Number			101. 2	ip Code			10g. Citizen of	What Country	7
	e 23	erai	21028 Woodmere I		van in 11 C	40 W D		0650		United		la dia a
20	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or itema 23a or 28a-f show event, the Madical Examinar must be notified at	y Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Wes Decedent E- Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	ver in 0,5.	1		Specify:	Specify Yes or No to Rican, etc.)		ce - American ick, White, etc. by: White	
21215-0020	natura rdical E	Completed by	15. Decedent's E (Specify only highest gro	ducation	16a.	Decedent's Us (Give kind of w	ork done	during most of wo	rking	16b. Kind of B	Business/Indus	try
12	withir	E G	Elementary/Secondary (0-12)	College (1-4or 5+	)	life. DO NOT				II C C		
9	filed withi Hygiene. Ither than		17. Father's Name (First, Middle, Last	<u> </u>		Progr	am M	anager	me (First, Middle,		overnm	ent
Maryland	e da S	o Be		,							,	
Z	should by	P P	Anastasios Verg		19h	Mailing Address	c /Street		lara H. urel Route Numbe			da)
Ma	T is	i										
စ်	of Health item 27 i	- 1	Deborah H. Vergo 20a. Method of Disposition	os_/ Wife	20b. Place of	UZO WOC Disposition (Na y, crematory or	dmero Ime of	e Drive,	Leonard	20c. Location		
<u>0</u>			1 Burial 2 □ Cremation 3 □	Removal from State					7012			
Baltimore,	permit. Pe Departmen Important: any injury pnce.		4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		Highla	nd Memo		ardens ;	4-26-05	Des Moi	nes, I	owa
Ba	permit. Pege Department of important: if any injury or once.		Edward N. Brinsfi	1	M00052			Br	insfield			
	100		23a. Part1. Enter the disease, or com shock, or heart failure. List only			ot enter the mo	de of dyin	g, such as cardia	c or respiratory ar	rest,		0650-0279 proximate erval Between
)	Physician /Medical		Immediate Cause (Final disease or condition	a Adenoi				Luna			On	erval Between set end Death
	Examiner	_	resulting in death)			onsequence of		7			-   -	
	uted J ansit	Examiner	•	b								
oʻ	tificate be executed ig physician end as the buriel-transit	Еха	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	U	ue to (or as e c	onsequence of	:					
68760,	ate by hysica the bu	edical	Cause (Disease or injury that initiated events resulting in death) Last	c	ue to (or as e c	onsequence of)	:					
9 X	entific ding p	N N		d								
Вох	ath c	Physician/M		<b>.</b>								
o.	the a	ysic	Part II. Other significent conditions	contributing to death but	not resulting in	the underlying	cause give	en in Part I.	23b. Did t	obacco use co	ntribute to the	cause of death?
P.0.	that the ed by detac								1×(	fes 2□No	3 Probabl	y 4 🗆 Unknown
Records,	law requires that the death cer as been signed by the attendin r 2 should be detached for use	ed by								an eutopsy		utopsy findings
eco	2 55 9	Completed							perior	med?	comple of deet	etion of cause h?
	E Se	ပ္ပ							1 🗆 Y	es 2 No	1 □ Ye	s 2 No
of Vital	Physician: The this certificete rai director, per	Be	25. Was case referred to medical exeminer?						ath (Check only o	ne)		
7	hysic his o	2	1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ER/Out	patient 3 D		4 U Nursing F	lome 5□ Resid	ence 6 DOth	er (Specify)	
Ē	rng P ifter t	Ë	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. T		28c. Injury Work		28d. Describe h	ow injury occur	red	
Si.	Attending I or death. octor: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not b			М		Yes 2 □ No				
Division	i or At efter o Direct	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	y - At home, far (Specify)	m, street, facto	y, office		28f. Location (S City or Tow		er or Rurel Ro	ute Number,
	To the Hospital or Attending Physician: within 24 hours efter death.  To the Funeral Director: After this certifical completely filled in by the funeral director.	edicai C	29a. Certifier 1 Certifying Ph	ysician: To the best of niner: On the basis of	my knowledge, Xamination and	death occurred	at the tim	e, date and place	, and due to the o	cause(s) and ma	anner as stated	f.
	the hin 2 than 1 than 1			and mariner state	nd.							
	5 × 5 × 5		29b. Signature and title of certifier	=/ 6/1 d/V	1/1/1	25	c. License	number		29d. Date signe	a (Month, Day,	rear)
			- IXCOX	/NOW	1111	4	ב ע	d176	(	lpril	di, al	105
		- 1	30. Name en ddress of person who		th (Item 23a) (	Type, Print)	[ ], ] :	Ideman	1 Pont	or On	1ifann	MM N
		1	John Scott	Tidball, M	(LD)	0,000	- 101	IGENOO	a CDIC			a, MD
H	Sta Registr	te ar	31. Date filed (Month, Day, Year)	2005 32. egistrar	s Signatu	April 1						

			1 - For State Registrar	State of Marylar	nd / Depa		lealth and N	Mental Hyg	iene	11.700
	Physic	an	1. Decedent's Name (First, Middle, Last)			-		2. Date of Deat Month	h Day Year	3. Time of Death
	/Medi		CATHERINE			VACCARO		APRIL	15 2005	7:39 A M
	Exami	ner	4a. Facility Name (If not institution, give				Location of Death		4c. County of Death	
			29090 LIVINGSTON  5. Social Security Number 6. Sex		last histhdays	MECHAN I	ICSVILLE  If Under 24 Hrs.	Data of Birth	ST. MARY'	
	Funeral Director			M 2⊠F	84 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, MARCH 2	Year) 9. Birthp Cour 5,1921 WASH	olace (State or Foreign htry) INGTON, DC
	show		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation			1	0d. Inside City Limits
	e Mai	ctor	MD ST. MARY	's MI	ECHANIC	SVILLE				1 ☐ Yes 2 🙀 No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cour	ntry?
	ath w	ra	29090 LIVINGSTON			20659			U. S. A.	
	ter dea items	une		12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	rs aft	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 😿 No If Yes, Give Year or Dates:		1 ☐ Yes 21X No	Specify:		Specify:	m r
21215-0036	within 72 hours after death with the Maryland ane. than "naturel; or items 23a or 28e-1 show the Medical Evertice from the notilitied at	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation		WHI  6b. Kind of Business/Inc	
215	hin 7.	pie	(Specify only highest grade	completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of world)	king		
21	should be filed within 72 hours after death with the Maryla Id Mental Hygiene, marked other than "naturel", or items 23a or 28e-1 shov imatic event, the Medical Evandiner must be notilified at	Completed	12		HOMEM	AKER			AT HOME	
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, N	faiden Surname)	
yla	2 should be t and Mental H is marked of eumatic ever	2	CAMILLO VACCARO					SONTAG		
Maryland	8 8 S		19a. Informant's Name/Relationship (Ty	•					City or Town, State, Zip	,
	s 1 and 2 of Health item 27 other tr		ANNA JORDAN / SIS  20a. Method of Disposition			LIVINGST sition (Name of			CSVILLE, MD	
Baltimore,	Pages nent of I int: if it		1 ☐ Burial 2X☐Cremation 3 ☐ R	lemoval from State	cemetery, crer	natory or other plac	1	PKIL	20c. Location - City or To	
量			<ul> <li>'4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>			D-ECHOLS			HARLOTTE HA	LL, MD
Ba	permit. Departr Importa any inj		Loun Bel		0641 30	105 TUDET	S NOTCU P	NSFIELD-	ECHOLS FUNL	.HME,P.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the dea	th. Do not ent					Approximate Interval Between Onset and Death
8760,		Ical Examiner	Sequentially list conditions, it is not be a sequentially list conditions, it is not be a sequentially cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec						
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of of 9 □ Unknown	aldeath 3□	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions cor	ntributing to death but not real	sulting in the un	nderlying cause give	en în Part I.		acco use contribute to the	ably 4 Unknown
Il Records,		Completed						24a. Was an autopsy perform	prior to conded?	psy findings available inpletion of cause of 2 No
Vital	iclen: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	lospital:		211		h (Check only one	)	
of	ding Phys	tlon: To	1 Yes 2 No Canal No C	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	v at	ome 5 x esider 28d. Describe hor	nce 6 Other (Specify w injury occurred	")
Division	i gitte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str			28f. Location (Str. City or Town,	eet and Number or Rura State)	l Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical (	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 1 Medical Examination (Check only one)	sician: To the best of my knonar: On the basis of examination and manner stated.	owledge, death ation and/or inv	n occurred at the time restigation, in my op	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner as state and place, and due to	ated. the cause(s)
	with To t	Σ	29b. Signature and title of certifier			29c. License			d. Date signed (Month, I	
)			1/26/a	W		D.	. 444	136 1	APRIL 16	2005
+	B5		30. Name and a dr ss of person who co	mpleted cause of death (Ite	ATE	Print)	102 Psuc	Mellon	PRIL 16	PORFMAD
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 8 2	32. Registrar's Sign.						

		1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of I			ene 20	05	14729
		1. Decedent's Name (First, Middle,	Last)				2. Date of Deat Month	n Day	Vons	3. Time of Death
Physic /Med		ROY		VA	N AKEN				005	2:40 AM
Exami		4a. Fecility Name (If not institution, g	give street and number	)	4b. City, Town, o	or Location of Death		4c. County	ol Death	
		Gilchrist				owson				imore
Funera		5. Social Security Number 220–30–1905	. Sex 7. A 1 M 2 □ F	ge (In yrs. last birthday) 93 Yrs.	Months Days		8. Date of Birth	Year)	9. Birthpl	ace (State or Foreign
Director		Usual Residence of Decedent		9)			10/8/	1911	Ne	w York
yland		10a. State 10b. County		10c. City, Town or L	ocation				10	Od. Inside City Limits
ith the Marylar or 28e-f show	ţċ	MD. Har	rford		Ja	rrettsvi	ille			1 ☐ Yes 2 X No
100 E 200	lre	10e. Street and Number			10f. Zip Code		11	g. Citizen of	What Coun	try?
	la la	2329 Cox 1				21084		Unit	ed S	tates
2,7	Funeral Director	11. Marital Status	12. Was Decedent Amed Forces	?	Was Decedent of his Yes, specify Cub	Hispanic Origin? (Sp Jan, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ck, White, e	
36 36 selfe	byF	1 ☐ Never Married 2 ☐ Married 3 🔣 Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Dates:	WW II	1 ☐ Yes 2 No	Specify:		Specif	y: 14	n i to
d 21215-0036 OTHO Hygiene. Item the Maryla Hygiene. Item than "natural", or itame 23e or 28e-1 shown, the Madical Examinar must be reutilized at				16a, Dece	edent's Usual Occur	pation		16b. Kind of B		hite
D 12 12 13	piet	15. Decedent's (Specify only highest		(Give	kind of work done DO NOT use retire	during most of work d)	ting	iob. itmo or b	201110334110	a on y
212 d with an entrangement of the second	Completed	Elementary/Secondary (0-12)	College (1-4or		uter sy	stems a	nalysis	So	cial	Securit
nd nd	Be	17. Father's Name (First, Middle, La	rst)		-	18. Mother's Nam	e (First, Middle, M			
Iaryland 2 2 should be filed and Mental Hygis Is marked other aumatic event, II	Tof	William		Van A			elmia			anders
re, Maryland 212 s 1 and 2 should be filed withi f Heelth and Mental Hygiene. Item 27 Is marked other than other traumatic event, the M		19a. Informant's Name/Relationship				t and Number or Rur				
E, M		Gerald Neil V	an Aken/S	30n 1.42	Murdoc	k Road				21212
		20a. Method of Disposition  1 Burial 2 Cremation 3						20c. Location		
Baltimo Sermit. Page Department of mportent: If on mportent: If on mportent: If on mportent: If one mportent: If one mportent of the mportent		`4 □ Donation 5 □ Other (Spe	cify) Di	ılaney Va		m.  4/2	6/2005	Timor	ium,	Marylan
Baltim Permit. Pa Department mportent any lojury		21. Signature of Suneral Service Li	ornste		2. Name and Addre		Jarrett	svill	e, M	aryland
		23a Part1 Enter the disease or o	omplications that cause			rtz & S	on Fune	ral H	lome,	P.A. Approximate
		23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final	nly one cause on each	Λ	itor the mode of dyn	119, 300/1 23 04/0140	or respiratory arre		3	Interval Between Onset and Death
Pnysician /Medical	_	disease or condition resulting in death)	a	tracture	2		~~~~	500	/2	DAYS
Examine			Due to (or a	s a consequence of):			-000	Mell		LPNC
- W	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s a consequence of):		No		LILLIE	-	1013
uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events				$\mathcal{V}$	X X O	LΚ		
60, be executed ician and burial-transiti	Exa	resulting in death) Last	Due to (or a	s a consequence of):			1	Sa. 1		
3760, ate be execu hysician and	cal		d			-//	SA. D.	•		
68 tiffice as th	Physician/Medical	IF FEMALE:				1/				
Box 68 eath certifica attending pt	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth		□Ectopic pregnanc	y V			ate of delive	,
. 5 0 5	slci	1 Yes 2 No	4□Pregnant : 9□ Unknown	at time of death 5	Other (specify) _		-	M	onth	Day Year
ecords, P.O. Box law requires that the death cer as been signed by the attendir 2 should be detached for use	Phy	Part II. Other significant condition	e contributing to doath	hut not enculting in the	underhing en en	una in Rost I	22a Did tob	2000 1100 000	tobute to th	e cause of death?
ires ti	by	Part II. Other significant condition	s continuenting to death	but not resulting in the t	underlying cause gr	ven in Fait i.	1 □ Ye			abiy 4 Unknown
requ	etec	-						N.		
0 a 2 c	Completed						24a. Was autops	/	Were autor prior to con death?	ssy lindings available apletion of cause of
Vital Rec										2 No
Division of Vital Records, To the Hospitel or Attending Physician: The law requires th within 24 hours after death. To the Funerel Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be	o Be	25. Was case relerred to medical examiner?  1 Yes 2 No	Hospital:		- Ott	har	th (Check only on	1/		1
Physical distribution	-	27. Manner of Death	1 ☐ Inpat	urv 28b. Time o	ALL SEL DOA	4   Nursing no	ome 5 Reside			hospia
On oding th. : Afte	tion	1 □Natural 5 □ Pending  Accident investiga	(Month, D	ay Year) Injury	of 28c. Inju Wo M 1	rk? ] Yes 2 No	FOURDON			-
Visi Atter r dea ector	ifica	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 200. Prace of it	niury - At home, farm, s	reet, factory, office	1.	28f. Location (St	eet and Numi		Route Number,
Blor safte	Certification:	4   Homicide	Home	etc. (Specify)	D LINNE	FACILITY)	City or Town		les Sr	BALTMORE W)
ospit hour unere	dical (	29a. Certifier Certifying	Physician: To the bes	t of my knowledge, dea	th occurred at the ti	ime, date and place,	and due to the ca	use(s) and m	anner as st	ated.
he H in 24 he Fu	a a	one)	and manner s	of examination and/or is tated.	nvestigation, in my	opinion, death occur	red at the time, da	ite and place,	and due to	the cause(s)
To t Com	Σ	29b. Signature and title of certifier	0		29c. Licens	se number	25	d. Date signe	ed (Month, L	Day, Year)
		Amou	My		カラ	8503	A	PRIL	22:	2005
10		30. Name and address of person w	ho completed cause of	death (Item 23a) (Type	Print)	8303	m 20	~//		
		AMALON CHARLES	1 m 6001		الا اد د	in worke	-11 44	4		
S Regis	tate trar	31. Date filed (Month, Day, Year)  APR 2 9		trar's Signature	Carle 5					,

026	03 i		i icase i		andream of the all the and t	-	_
l			1 _ For Stete	State of Maryland / Dep		vientai Hygie	ne 11.720
_			Registrar		ertificate of Death		No. 000 14/30
	Physici	an	Decedent's Name (First, Middle, Last)	) , ,,,,,,		2. Date of Death	3. Time of Death
	/Medi		Ihomas ' r	aul Willian	m S	April	14, 2005 6:32 P M
	Examir	er	4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death	ו	4c. County of Death
			Peninsula Regional		Salisbury		Wicomico
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda)  M 2□ F  Vrs.	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth Month, Day, Y	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	7 1 1100		May 18,	1957 MD
	land ow		10a. State 10b. County	10c. City, Town or I	Location		10d. Inside City Limits
	Mary fish	ρ	MD Some	RSET Prince	ss Anne		1 Tyes 2 TNo
	1 the	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Country?
	3a o	Ü	11983 Drexwood	od DR.	21853		11.S.A
	be tiled within 72 hours atter death with the Maryland nat Hygiene. So other than "natural", or Itams 23a or 28a-f show event, I're Medical Exartiner must be nutified at	Funeral			B. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian,
9	atter or its	F	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give	1 Yes 2 No Specify:	o Hican, etc.)	Black, White, etc.
5-0036	ral',	Completed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	To res 20 Specily.		Specify: Slach
5	72 h natu	etec	15. Decedent's Educ (Specify only highest grade	cation 16a. Dec	edent's Usual Occupation re kind of work done during most of wor . DO NOT use retired)	king 16	b. Kind of Business/Industry
21	within iene. than '	ig.	Elementary/Secondary (0-12)	College (1-4or 5+)	• .		Catevia
121	tiled w Hygie other ti		17 Fash and Alama (First A findalla ( and)		LaborER	- 15: 15:15:15:15	Catering
and	be ti	Be	17. Father's Name (First, Middle, Last)	C		ne (First, Middle, Ma.	
3	2 should be and Mental Is marked of aumatic ev	2	Noah William			a Wrig	חד
Maryland			19a. Informant's Name/Relationship (Type		iling Address (Street and Number or Ru	224	
	s 1 and if Health item 27 other tr		Seth J. Benne 20a. Method of Disposition	20b. Place of Disp	O Adam Farm Par	Date 20	rcensboro N.C 327407 c. Location - City or Town, State
٥	Pages nent of I int: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State cemetery, cr	ematory or other place)	1	1
Baltimore			* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	31. Char	les U.M.C Cem. OH.	- 22 - 25	Chance, MD
Ba	permit. Departr Imports any inju		21. Signature of Fortieral Service Coeffse	· +	2. Name and Address of Facility An Thom, E. Ward 30689 Hampdon An	Funeral H	out 112 21062
			23a. Pari . Enter the di, ease, or compli	cations that caused the death. Do not e	ater the mode of dving, such as cardiac	or respiratory arrest	5 Anns, 110 21853 Approximate
	100		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	00 00		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Congilications of (	In adustace	normal	
	Examiner			Due to (or as a consequence of):			
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):			
	be executed sician and burial-transit	Examiner	Cause (Disease or injury				
Ć,	exect n and ial-tra	Еха	that initiated events cresulting in death) Last	Due to (or as a consequence of):			
160	death certificate be executed e attending physician and of tor use as the burial-transit	icall					
.89	ifficate g phys as the			700			
ŏ	leath certificat attending phy I for use as th	Z	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of delivery
ω.	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
P.0	oy th ache	Physician/Med	9 🗆 Unknown	9□ Unknown			
S, F	res that igned b	by P	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ğ	w require been sig should b					1 ☐ Yes	2 No 3 Probably 4 Unknown
Record	aw re	piet				24a. Was an	24b. Were autopsy findings available
Ä	The lav	Completed				autopsy performed 1 ☐ Yes 2 ☐	
Vital		0	25. Was case referred to medical		26. Place of Dea	th (Check only one)	10 10 20 10
>	8 W TD	OB	examiner? 1 X Yes 2 ☐ No	ospital: 1 Inpatient 2X ER/Outpatie	ent 3 DOA Other: 4 Nursing H	ome 5 Residenc	e 6 Other (Specify)
ιof	ding Phy h. Atter thi tuneral	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c, Injury at	28d. Describe how	
io	Attending or death. ector: Alter by the tune	atio	1 Natural 5 Pending 2 Accident investigation	(mening say roar) inquity	M 1 ☐ Yes 2 ☐ No		
Division	l or Attendater death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number,
Ö	tal or A rs after al Direct ed in by	Cer		g, (-,)/			
	To the Hospital or within 2 <sup>o</sup> hours after To the Funeral Direction completely filled in I	edi al	29a. Certifier 1 Certifying Phys	sicien: To the best of my knowledge, dea ner: On the basis of examination and/or	ath occurred at the time, date and place	, and due to the caus	e(s) and manner as stated.
	the hin 2 the F	ledi	one)	and manner stated.			
	To With	Σ	29b. Signature and title of certifier	$\gamma$	29c. License number OCME	29d.	Date signed (Month, Day, Year)
			I header M.	ling mus		A	pril 15, 2005
			30. Name and address of person who co		111 Penn Stre	et Ralti	more, Maryland 21201
200			THEODORE Mile				intriduid 21201
×	Sta Registi		31. Date filed (Month, Day, Year)  APR 1 8	32. Registar's Signature	1		
DH	MH 17 Rev 1/2		71711 10	rods harme to	Residence		
211	1411 17 116V 1/2	JU 1					

		ı	1 - For Stata Registrar	State of Ma	ryland / Depa	artmen	t of Health	and Me	ental Hygi	ene	75 m
			Decedent's Name (First, Middle, Last)	)					2, Date of Death	2.0	3. Time of Death
	Physici		Oran Rich	ard	Wilkerson				Month April		Year 005 10:10 a.m.
	/Medic Examin	_	4a. Facility Name (If not institution, give		WIIRCISON	4b. City,	Town, or Location		p :	4c. County o	
		•	23814 Kingston	n Creek Ro	ad		Califor	rnia		St.	Mary's
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday)	If Under Months	1 Year If Under Days Hours	r 24 Hrs. 8	3. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director		214-36-2069	M 2□F	90 Yrs.	WOTHERS	Duys		May 8,		Indiana
	put		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	lanyli sho	5			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0.116				1 ☐ Yes 2 € No
	28e-	ect	Maryland St. Ma:	ry's		10f. Zip	Californ	nia	10	g. Citizen of W	hat Country?
	with Se or			. Cmaole Pa	o d	1011.23.0	20619		"		States
	ns 2	Funeral Director	23814 Kingston	12. Was Decedent E		Vas Deced	ent of Hispanic Or ify Cuban, Mexica	rigin? (Spec	ify Yes or No-		- American Indian,
9	or Iter	Ξ	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🛃 N	0				ican, etc.)		, White, etc.
03	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show lical Exacting out by motified at	i by	3 d Widowed 4 □ Divorced	If Yes, Give Year or Dates:		I□Yes 2	2 No Specify.	:		SpecifyW	Mhite
21215-0036	72 h	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)	(Give	kind of wor	l Occupation	st of working	1	6b. Kind of Bus	iness/Industry
21	vithin ne. han "	ldm	Elementary/Secondary (0-12)	College (1-4or 5-	+)	DO NOT us					
	lled v dygie ther t		17. Father's Name (First, Middle, Last)	1	Pos	t Mas		or's Namo	First, Middle, M		stal Service
Maryland	ntal hed of	Be		*****1			10.141001				•
7	12 should h and Me 7 is mark reumation	우	William Scott  19a. Informant's Name/Relationship (7)			a Address	(Street and Numb		a Lucil		
Ma	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23e or 28e-1 show any fourty or other treumatic event, the Marical Examinet must be multiled at anone.		Bonnie Jean Herna								
ē	s 1 au f Hea item othe		20a. Method of Disposition	_	20b. Place of Dispo	sition (Nam	ne of	Da			City or Town, State
Baltimore,	Page nent o nt: M		1 ☐ Burial 2   Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)		Brinsfiel			4-24-2	.005 C	harlott	e Hall, MD
alti	mit. partm porte y Inju		21. Signature of Fineral Services Licens	967							Home, P.A.
Ö	Departing any Irr		Edward N. Brinsfi	ta, Jr							MD 20650-0279
		y.	23a. Part1. Enter the disease, or composition shock, or heart failure. List only o	ications that caused ne cause on each line	0	4111		s cardiac or	respiratory arres	st,	Approximate Interval Between
	Physician	ĺ	Immediate Cause (Final disease or condition	Pros	TATE	ANC	ER				Onset and Death
	/Medical Examiner		resulting in death)	4	consequence of):	-					77,77000
	Examine	L	Sequentially list conditions,	b. ————————————————————————————————————							
	sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):						
_	and and Il-tran	xan	that initiated events resulting in death) Last	Due to (or as a	consequence of);						
760,	ate be executed hysician and the burial-transit	cal E	l								
687	death certificate be executed the attending physician and of for use as the burial-transit			o							
Вох	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of		e'. Di 20				23d. Date	of delivery
	death e atte	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t		Ectopic pre Other (spe				Mont	th Day Year
P.0	at the by th	Physician/Med	9 Unknown	9□ Unknown							
	law requires that the de. as been signed by the a 2 should be detached f	by	Part II. Other significant conditions co		4.5-	derlying ca	use given in Part I	1.			oute to the cause of death?
ord	w require been si should I	ted	CFIRBROVASC		SEASE				1 L Yes	2 X No 3	3 ☐ Probably 4 ☐ Unknown
Records,	law las b	Completed	HYPERTEUS/0	N					24a. Was an autopsy	24b. We	ere autopsy findings available for to completion of cause of
H H	sician: The law certificate has b irector, page 2 s	Con	ATRIAL FLARI	CLATION					perform 1 Yes 2		ath? □Yes 2█No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			0.1		Check only one		
of	Phy rthis ral d	: To	1 ☐ Yes 2 No  27. Manner of Death	1 L Inpatier	nt 2 ER/Outpatien 28b. Time of		4 114		e 5 Residen		
on	ding Phy h. After thi funeral o	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) Injury	м	Bc. Injury at Work? 1 ☐ Yes 2 ☐			,,	•
Division	Attending r death. sctor: After by the fune	ifica	3 Suicide 6 Could not be	28e. Place of Inju	ry - At home, farm, stre	eet, factory,	, office	28	f. Location (Stre	et and Number	r or Rural Route Number,
Ö	el or s afte il Dire	Certification:	4 Homicide determined	building, etc.	. (Specify)				City or Town,	State)	
	To the Hospitel or Attend within 24 hours after death To the Funeral Director; completely filled in by the		29a. Certifier 1 Certifying Phy (Check only 2 Medicel Exami	sicien: To the best o	f my knowledge, death examination and/or inv	occurred a	at the time, date ar	nd place, an	d due to the cau	ise(s) and mani	ner as stated.
	the H iin 24 the Fi	Medical	one)	and manner stat	led.			atti occurrec			
	With Con	2	29b. Signature and title of certifier		. ^		License number	-1	294	d. Date signed	(Month, Day, Year)
	100		your L 10	annel "	-(2)	D	20170	2 ~		Tide	x/ as
1	) 131		30. Name and address of person who con TOWN L BENNETT		eath (Item 23a) (Type, I	Print)	20190 L RUAD	(V.	17.1.111	40-	2019
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	r's Signature		- NORD	CAL	LI BLUIA	1000	- 301/
	Regist		APR 25	2005	w It p	ment.	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 14, 2005 Joyce Bauman Wohlstetter April 6:25 P /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2√2 F Yrs. 410-46-4231 79 04-25-1925 Director Memphis, Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Worldal Examiner must be notified at 1 Ty Yes 2 □ No Directo Montgomery Chevy Chase 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5803 Kirkside Dr. 20815 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Is marked other than Elementary/Secondary (0-12) 12 Colfege (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Saul Bauman 2 Pauline Solomon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Alan F. Wohlstetter / Spouse 5803 Kirkside Dr., Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages nent of h 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Mt. Comfort Crematory 04/18/2005 Alexandria, VA 22. Name and Address of Facility Joseph Gawlers Sons INC. 21. Signature of Funeral Service Licensee M01378 5130 Wisconsin Ave. NW, Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHERO SCLERUST C Pnysician CARDIDVASCULAR /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Due to (or as a consequence of): 68760, Physician/Medical Box ( IF FEMALE 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1¥Yes 2□ No Certification: To 28b. Time of Injury 28c. injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

O'BRIEN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m

8600

OLD

29c. License number

GENSETOWN

31027

29d. Date signed (Month, Day, Year)

		•	1 - For Stete Registrer	State of M	larylar		artment rtificate			and Me	-	giene	200	15 11.73
	Dhariai		1. Decedent's Name (First, Middle, Last)								2. Date of De.			3. Time of Death
	Physici /Medic		Robin Teresa Will	iams							Month APRIL	/3	2005	1:35 PM
	Examin		4a. Facility Name (If not institution, give s				4b. City, T	own, or	Location o	of Death		4c.	County of Dear	
			Doctors Communit	<del></del>			Lan						ince Ge	
п	Funeral		5. Social Security Number 6. Sex		ge <i>(In yrs.</i> 50	last birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	B. Date of Birl (Month, Da	h y, Yea <i>r</i> )	9. Birt	thplace (State or Foreign ountry)
	Director		579–72–5847 Usual Residence of Decedent								9/25/5	4	Was	h.D.C.
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	a-f s	ctor	Md. Annapoli	.S		Annapo	lis							Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip (	Code				10g. Cit	izen of What Co	ountry?
	23a		# 57 Regatta Bay	# 3			2	1401				Ü	S.A.	
	er de	Funerai		<ol><li>Was Decedent Armed Forces</li></ol>	?	J.S. 13. \	Was Decede f Yes, specif	ent of His fy Cubar	spanic Orig n, Mexican	gin? (Spec , Puerto R	ify Yes or No ican, etc.)	-	14. Race - Ame Black, Whit	e, etc.
36	rs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 If Yes, Give Year or Dates:	No		1 ☐ Yes 2	No No	Specify:				. A	frican- merican
o O	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "neturel", or liems 23a or 28e-f show event, the Medical Ever, in withing the traffic of an	ed	15. Decedent's Educ			16a. Deced	dent's Usual	Occupa	tion			16b K	ind of Business/	
15	n "ne	Completed	(Specify only highest grade	completed)	F.\	(Give	kind of work DO NOT use	done d	urina most	of working	9	100. K	ind or pasitiessy	industry
212	e filed within al Hygiene. other then '	mo:	12th	College (1-4or	5+)	Auto	matio	n Cl	erk			II.S	Posta	l Service
bu	e filed al Hygi I other vent, I	ВеС	17. Father's Name (First, Middle, Last)							r's Name	(First, Middle,			1 DCI VICE
<u>ylaı</u>	should be and Mental marked o umatic eve	<u>ا</u> و	Bernard Fletch	er					Rut	h Ve	SS			
Maryland 21215-0036	S P E E		19a. Informant's Name/Relationship (Typ	· ·								-	r Town, State, 2	Zip Code)
≥, ≥	and lealth m 27 her tr		Afrika Williams/Da	ughter									21403	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 is marke any injury or other treumatic once.		20a. Method of Disposition  ¹✗☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	206. 1	Place of Dispo cemetery, cren	sition (Name natory or oth	e of her place	a)	Da	te	20c. Lo	ocation - City or	Town, State
ţ	t. Pa tmen tent:		`4 □Donation 5 □ Other (Specify)		Ha	armony				1/19/	05	Lan	dover,	Md.
Bal	permi Depar Impo any ir		21. Signature of Funeral Service License		1 2 H	22	Name and	Addres:	s of Facility ngton	y 1 & So	ons Co.	. In	C.	
			23a. Part1. Enter the disease, or compli-	cations that cause	d the deat	th. Do not est	25 Bu	rrou	gńs A	lve.,	V.E., Wa	ash.	D.C.	20019 Approximate
Н			shock, or heart failure. List only on Immediate Cause (Final	e cause on each	line.								20	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	METAST			ST C	ANC	ER	TO	THE I	しいり	65	
П	Examiner			Due to (or as	s a consec	quence oi):								
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consec	quence of):								
	uted	Examiner	Cause (Disease or injury that initiated events											
o,	an an rial-tr		resulting in death) Last	Due to (or as	a consec	quence of):								
8760,	the death certificate be executed y the attending physician and ched for use as the burial-transit	dicai												
9	ing ph	Med	IF FEMALE:					. <u> </u>						
Вох	eath certific attending p i for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth	2 Feta	al death 3	Ectopic pre						23d. Date of del	ivery Day Year
0	the a	/sic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	at time of o	death 5□	Other (spe-	cify)				İ	WOIT	Day Teal
٩	that the died by the detached		Part II. Other significant conditions con	tributing to death l	but not res	sulting in the ur	nderlying car	ISA TIVA	n in Part I		23e Did to	phacco i	ise contribute to	the cause of death?
Records,	igi be	d by	•				,g .a.	g c			1 🗆 Y			obably 4 ☐Unknown
Sor	> 4	ete												
Re	The law ate has b page 2 st	Completed									24a. Was autop perfor	SV	prior to death?	topsy findings available completion of cause of
a	in: Th ificate or, pag	e Co	25. Was case referred to medical								1 Yes	2 <b>/N</b> 0	1 ☐ Yes	2 🗆 No
Vital	Physician: this certific al director,	o B	examiner?	ospital: 1 X Inpati	ient 2	ER/Outpatien	t 3 DOA	Othe	e-	•	Check only o		6 □Other (Spec	-4.)
of		T :u	27. Manner of Death	28a. Date of Inju	ury	28b. Time of		c. Injury	at		d. Describe h			any)
ion	Attending Prodeath. Sector: After by the funeral	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Da	ay rear)	Injury	м	Work 1 □ Y	? 'es 2 🗍 N	No				
Division	ol or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In	jury - At h	ome, farm, stre	eet, factory,	office		28	If. Location (S City or Tow	treet an	d Number or Ru	ıral Route Number,
	rs afte			January, J							0.0, 0.7.07.	n, Olaio	,	
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) (Check only one) (Check only one)	icien: To the best er: On the basis of and manner s	of examina	owledge, death ation and/or inv	occurred at estigation, i	t the time	e, date and inion, deat	d place, an h occurred	d due to the d at the time, d	ause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier				29c.	License	number			29d. Dat	e signed (Monti	h, Day, Year)
)			7100mls	Kins M	D		P	431	62			4	14/05	-
R	(4)		30. Name and address of person who co	mpleted cause of	death (Iter	m 23a) (Type,	Print)		10	10				
			MELVIN GASKINS, MI	1831	DELL	E POIN	IT DR	. 6	KEEF	NBEC	1, MD	Li	776	
	Sta Regista	-	APR 1 8 2005	2. Regist	rars Signa	ature	E)							

DHMH 17 Rev 1/2001

Williams · Robin Teresa

		1 - For State Registrar	State o		nd / Dep	artment of I	Health and	Mental Hy	giene Reg. No	2005	1473
Physici /Medic		negistrar     Decedent's Name (First, Middle Virginia	M.		Win	ters		2. Date of De Month April	Day 14		3. Time of Death 1:05A
Examin Funeral Director		4a. Facility Name (If not institution  Renaissance Cardens  5. Social Security Number  578–28–8434	@ Riderwood	d Village 7. Age (In yrs.				s. 8. Date of Bir	th IV. Year)		
e Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince	ce Georg		ty, Town or Lo	cation Spring					10d. Inside City Limit
th with th 23a or 20 1st be no	Funeral Directo	3128 Gracefield	Road, #6	502		10f. Zip Code 20904	Į.		-	izen of What Cou Lted Stat	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinant must be notified at once.	by Funer	11. Marital Status  1 □ Never Married 2 □ Marr  3 ☆ Widowed 4 □ Divorced	Armed Fo	2 No ve No	.S. 13.	Was Decedent of lift Yes, specify Cub		Specify Yes or No rto Rican, etc.)	)=	14. Race - Ameri Black, White, Specify:	
vithin 72 ho ne. han "natur e Medicel	Completed	15. Deceden (Specify only highe: Elementary/Secondary (0-12)	's Education it grade completed)	-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of wo d)	orking	16b. K	ind of Business/Ir	
id be filed v ental Hygie ked other t Ic event, III	To Be Col	17. Father's Name (First, Middle, John L. Reid	Last)		Homer	aker		me (First, Middle, Milstea		OWN hor	ne
and 2 should all half Mark marks are traumated	-	19a. Informant's Name/Relations Constance W. Mo	nip (Type, Print) EGlynn –da		3128		and Number or Reld Road,	ural Route Numbe #602 Si	er, City o lver	r Town, State, Zij	Code) Md. 20904
Pages I ment of He ant: if itan ury or oth		20a. Method of Disposition 1  Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		01-1-	cemetery, cre.	esition (Name of matory or other pla coln Ceme	tery 4/1	Date 8/2005		entwood,	own, State Maryland
Depert import any in		21. Signature of Funeral Service  Donald  23a. Part 1. Enter the disease, or	Boye	art	44	nald V. 00 Powde	r Mill R	oad Belt	svil	me, PA le, Mary	land 2070
hysician /Medical	١	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	aPn	aused the deat ach line. eumonia or as a conseq	1	er the mode of dyl	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death days
this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the buriat-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underhing Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (		Artery (uence of):	Disease					
y the attending priched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		inth 2 ☐ Feta ant at time of c	al death 3	Ectopic pregnanc	у			23d. Date of delive Month	ery Day Year
been signed b	by	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the u	nderlying cause gr	ven in Part I.		obacco u	_	he cause of death?
certificate has beerector, page 2 sho	Completed									prior to co death?	epsy findings availab impletion of cause o
s certif	o Be	25. Was case referred to medical examiner?  1 Yes 2X No	Hospital:	npatient 2	ER/Outpatier	. 20 DOA O#		ath (Check only o			
a fee	<b> </b>	27. Manner of Death  1 Natural 5 Pendin 2 Accident investig	28a. Date of (Mont	of Injury h, Day Year)	28b. Time o Injury	28c. Inju	ry at	dome 5 ☐ Resident 28d. Describe h			у)
To the hospital of Attending within 24 hours after death.  To the Funaral Diractor: After completely filled in by the fune.	Certification:	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	ned 289. Place buildii	ng, etc. (Specif	(y)	eet, factory, office		City or Tov	vn, State		
24 hou Funa etely fil	edicai	29a. Certifier 1 ☐ Certifyin (Check only 2 ☐ Medical one)	g Physician: To the Examiner: On the ba and mann	isis of examina	owledge, deat tion and/or in	n occurred at the til vestigation, in my o	me, date and place opinion, death occi	e, and due to the urred at the time,	cause(s) date <i>a</i> nd	and manner as s place, and due to	tated. the cause(s)
within To the	Me	29b. Signature and title of certified	reil o			29c. Licens D34	se number 4590			e signed (Month, oril 14,	* '
10		30. Name and address of person Roy Fried, MD	who completed caus 3110 Grace	e of death (Item efield	n 23a) (Type, Road S	Print) ilver Spi	ring,Mary	land 209	904		
Sta Registr		31. Date filed (Month, Day, Year)	5 2005 <sup>32.</sup>	gistrar's Signa	ature	nacks					

Wasylczuk, Nicholas Baltimore Maryland 21215-0036

				Please	Type or Prin					-		•		
		•	1 - For State Registrar			<b>,</b>		tificate of			Reg. N	(11115	1473!	
				ne (First, Middle, Las	st)				_	2. Date Mont	of Death	ay Year	3. Time of Death	
	Physicia /Medic		Nicholas	s Wasylczu	k					Apr			2:30 A M	
	Examin		4a. Facility Name	(If not institution, give	street and number)			4b. City, Town, o		Death	4	c. County of Death	1	
			Union Ho					Elkton		Um I	Cecil			
	Funeral		5. Social Security 220-18-3	Number 6. S	ex X M 2□ F 7. Ag	ge (In yrs. la 8 (	ast birthday) O Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min (Mon	h, Day, Yea	r) Coi	nplace (State or Foreign Intry) MD	
	Director		Usual Residence			01	0			Janu	iary z	9,1925	IND	
	yland now		10a. State	10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits	
	Mar iffed	tor	MD	Cecil		C	hesape	ake City					1 Yes 🗶 No	
	or 28	ire	10e. Street and N	umber				10f. Zip Code			10g. C	Citizen of What Co	untry?	
	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Ither than "natural", or Items 23a or 28a-f show ant, Itte Mardical Examana mount be notified at	Funeral Director		tnut Sprin				21915				SA		
	er de	nne	11. Marital Status	rried 2 Married	12. Was Decedent	?	5. 13.	Was Decedent of I f Yes, specify Cub	Hispanic Origin an, Mexican, F	1? (Specity Yes Puerto Rican, et	or No- c.)	14. Race - Amei Black, White		
2	rs aft	by F		4 Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dates:	ωω Ι	1	1□Yes 2KDNo	Specify:			Specify: Wh.	ite	
5	2 hou			15. Decedent's Ed	ducation		16a. Dece	dent's Usual Occu	pation		16b.	Kind of Business/l	ndustry	
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2	tal H d oth d oth even	Be		e (First, Middle, Last)						Name (First, M		en Sumame)		
<u>8</u>	should nd Men marke imaric	10	Paul Was	J	Time Orient		10h Maille	- Address (Cases		a Sloboo		or Town, State, Z	in Code)	
	permit. Pages I and 2 should be filed within 72 hours after death with the Maryla. Bongertment of Health and Mantal Hygiens. Bongertment of Health and Mantal Hygiens. Bongertment of Health and marked other than "natural", or Items 23a or 28a-1 show any injury or other treumatic event, Itte Marical Examt in court be rediffied at once.			Name/Relationship (*) Wasylczuk	**			-				eake Cit		
ָ ב	1 and Healt em 2		20a. Method of Di		/wige	20b. Pl		sition (Name of matory or other pla		Date Date		Location - City or	,	
2	ages int of t: If it		1 💢 Burial 2	2 ☐ Cremation 3 ☐ n 5 ☐ Other (Specify		' [				10 0001	Cho	1 = 100 = h0	C:+ UD	
allino	nit. Partme artme ortan injur.			Funeral Service Licer		31.	22	Of Lima 2. Name and Addre	ess of Facility[	2.T. Foo	and Fu	sapeake neral Hoi	$mo D \Delta$	
0	permi Depar Impo any ir once			had &	1 1	مريد						e City. 1		
			23a. Part . Enter	r the disease, or comeant failure. List only	plications that cause	d he death						c overy,	Approximate Interval Between	
	Pnysician		Immediate Cause disease or condit	e (Final	O A	110	Mus	Sound	1/-	Tinfavo	tim	2	Onset and Death	
	/Medical		resulting in death		aD e to (or as	s a consequ	ence of:	o l	4 (	CHICIVI	110	1	10 vetre,	
	Examiner		Sequentially list of	conditions	b. End	Sta	196 1	Mateg	lava	liomy	1 mt	Ky	141.	
	р : <u>;</u>	Examiner	Sequentially list of if any, leading to cause. Enter Und Cause (Disease of	immediate derlying	Due to (or as	consequ	ence of):	l		L		/	0	
	e executed sian and urial-transit	cam	that initiated even resulting in death	nts 🔳	c Due to (or as	a consequi	ience of):							
Ď,	be ex ician burial	=				s a consequ	ierice or).							
199	eath certificate be exattending physician for use as the buria	edica		•	d									
	death certificate e attending phys d for use as the	/Me	IF FEMALE:	ont program	23c. If yes, outcome							23d. Date of deli	verv	
מס	atter for u	Physiclan/M	23b. Was deceded	12 months?	1□Live birth 4□Pregnant a			Ectopic pregnand Other (specify) _	У			Month	Day Year	
j.	the d y the achec	nysi	1 L Yes 3 9 □ Unknow		9□ Unknown									
, ,	v requires that the death been signed by the atte should be detached for	by P	Part II. Other sign	nificant conditions	contributing to death	but not resu	ılting in the u	nderlying cause g	ven in Part I.	23e.	Did tobacco	use contribute to	the cause of death?	
Ë	w require been sig should b		Did	be les	MelliT	US					1 🗌 Yes	2 <b>⊠</b> No 3 □ Pro	obably 4 Unknown	
ecords		Completed			/					24a.	Was an autopsy	24b. Were au	topsy findings available completion of cause of	
r	i <b>ician</b> : The lay certificate has rector, page 2	mo								10	performed?	death?	2 No	
VITAI	ysician: is certific director,	Be (	25. Was case ref examiner?	ferred to medical						f Death (Check				
010	Physician: this certific ral director,	2	1 ☐ Yes 25				ER/Outpatier					6 ☐Other (Spec	eity)	
Ĕ	ding P h. After t	ion	27. Manner of De 1 X Natural	5 Pending	28a. Date of Inj (Month, D	ay Year)	28b. Time o Injury	Wo	irk?		cribe now in	ury occurred		
UIVISION	ttend death tor: /	icat	2 Accident	6 Could not b		isine - At ho	me farm st		]Yes 2 □ No		tion (Street	and Number or Ru	ral Route Number	
$\geq$	al or Attending F s after death. I Director: After d in by the funera	Certification;	4 🗌 Homicide	e determined	building, e	tc. (Specify	()	reet, factory, office		City	or Town, Sta	ite)	Tai Fronto Frantoci,	
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier	1 € Certifying Ph	nysician: To the bes	t of my know	wledge, deat	h occurred at the t	me, date and	place, and due t	o the cause	(s) and manner as	stated.	
	e Hos 24 h e Fur letely	edicai	(Check only one)		minar: On the basis and manner s	of examinat								
	To the within 2 To the Complet	Me	29b. Signature a	hd title of certifier		/		29c. Licen	se number		29d. E	ate signed (Month	n, Day, Year)	
			1/1	Main	1/ /1	1000	w	2	2591	15		4-150	5	
	Ry JK		30. Name and ad	ddress of person who	completed cause of	death (I)em	23a) (Type,	Print)	1	2,		- 1		
	5 "		////	WHigh.	JX 500	100	114	LIKI	on	Ma	20	12/		
	Sta		31. Date filed (M	TPR 1 8 20	Regis	trar's Signa	ture	well .				•		
	Regist	rar		TO TO	os june		1						\$	

DHMH 17 Rev 1/2001

			For State Registrar	•	ryland / Dep		Health an	d Mental Hy	•	To be seen of	+736
			Decedent's Name (First, Middle, Last)					2. Date of De	ath		e of Death
	Physicia			GEORGE	WILLIA	M WHITE	, JR.	APRIL		Year 5 6:3	0 P M
п	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town	, or Location of D	Death	4c. County o		
		•	CARROLL LUTHERA	N VILLA	GE	WEST	MINSTER	₹	CARI	ROLL	
	Funeral Director		5. Social Security Number 6. Sex 216-12-6411		(In yrs. last birthda 82 Yrs.	y) If Under 1 Yea Months Day		Min. (Month, Da		9. Birthplace (Sta Country) MARYLAN	
	and	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. insid	e City Limits
	f sho	5	MD. CARROL	L	WESTMIN	ISTER				1 🗆 `	fes 2∑No
	the t	Director	10e. Street and Number			10f. Zip Code	9		10g. Citizen of WI	hat Country?	
	3a or		746 WINCHESTER	DR		2.	1157		USA		
	ms 2	Funeral		2. Was Decedent E	ever in U.S. 13	1		? (Specify Yes or No Puerto Rican, etc.)		- American Indian	١,
9	after or Ite	F	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ N If Yes, Give	lo	1 ☐ Yes 2X N		ruento Alcan, etc.)		, White, etc.	
5-0036	ours ral',	d by	3 Widowed 4 □ Divorced	Year or Dates:	WWII	10.703 22.11	ю ороспу.		Specify:	WHITE	
5-	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Madical Examinar must be notilited at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Gi	edent's Usual Oco ve kind of work dor . DO NOT use ret	ne during most of	f working	16b. Kind of Bus	iness/Industry	
2	within ane.	m	Elementary/Secondary (0-12)	College (1-4or 5	+)	OL & DI		R	MANUFAC	TURING	
2	filed Hygie Sther ent, II	ပိ	12 17. Father's Name (First, Middle, Last)					Name (First, Middle	. Maiden Sumame	······································	
Maryland 2121	ld be ental ked o	To Be	GEORG	E WILLIA	AM WHITE	, SR.	HELE	N A. KLA	SS		
ary	should ind Men marke	<b> -</b>	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Ma	iling Address (Stre	et and Number o	or Rural Route Numb	er, City or Town, S	itate, Zip Code)	
	and 2 salth a n 27 ls		SHERRI-LE BREAM	-DAUGHT	TER 746	WINCHE	STER D	R., WEST	MINSTER	MD.	21157
Š.	of He of He Item		20a. Method of Disposition			position (Name of rematory or other p		Date		City or Town, State	
Ē	Pages nent of ant: If It ary or o	1.3	1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	Inoval from State	ALL COUN	TY CREM	MOITA	4/11/05	SYKESVI	LLE, M	D.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural, or liems 23a or 28a-f show any injury or other traumatic event, In a Modical Examinat must be notified at once.		21. Sanature of June 1 Service License			22. Name and Add	dress of Facility	FLETCHER T., WESTM	FUNERA	L HOME	1157
Т			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused	the death. Do not e	inter the mode of c	tying, such as ca	rdiac or respiratory a	ırrest,	Approxi Interval	mate Between
	Physician ·		Immediate Cause (Final disease or condition	Seve		ardiomy		G		Onset a	nd Death
	/Medical		resulting in death)	Due to (or as	a consequence of):	1101010	1	J			
	Examiner		Sequentially list conditions,								
	sit ad	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):						
	and I-tran	Examiner	Cause (Disease or injury that initiated events cresulting in death) Last	Due to (or as	a consequence of):						
760,	icate be executed physician and s the burial-transit	cal E			, ,						
687			d			_					
Box (	The law requires that the death certifical ate has been signed by the attending phypage 2 should be delached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome					23d. Date	of delivery	
m.	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		B □Ectopic pregna □ Other (s <i>pecify)</i>			Mont	th Day	Year
P.O.	it the by th tache	hys	9 🗆 Unknown	9□Unknown							
	w requires that s been signed b should be deta	by F	Part II. Other significant conditions con	tributing to death bu	ut not resulting in the	underlying cause	given in Part I.	1	tobacco use contril		,
ord	equir	ted						_ 10	Yes 2 □ No	3 Probably 4	GONKNOWN
Vital Records,	has be ge 2 sh	Completed						24a. Was	psy pr	ere autopsy findir for to completion	ngs available of cause of
<u> </u>	The	Con						1 Yes		eath?	
/ita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:			Othor	f Death (Check only			
o	Physician: r this certifica ral director, i	10	1 Yes 2 No	1 ☐ Inpatie	nt 2 ER/Outpat y 28b. Time	iaur 3 DOA	4 La Nursi	ing Home 5 Res	idence 6 Other		
UQ	ding Phys h. After this funeral di	tlon	1 Aatural 5 Pending	(Month, Day	Year) Injun		njury at Vork? □Yes 2□No				
Division	f or Attending after death. Director: After I in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Inju	ıry - At home, farm,			28f. Location	Street and Number	r or Rural Route I	Vumber,
<u>S</u>	after after I Direct	Certification:	4  Homicide	building, etc	c. (Specify)	•		City or To	wn, State)		
	To the Hospital or Atlending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phys	ician: To the best	of my knowledge, de	ath occurred at the	time, date and	place, and due to the	cause(s) and man	ner as stated.	20(0)
	he Hi in 24 he Fu pletel	edical	(Check only 2 Medical Examir one)	and manner sta				occurred at the time,			
	To t com	Σ	29b. Signature and title of certifier	MO			ense number		29d. Date signed		-
•	1500		moclo			D	52035		MPYIL	11 2	005
	Marin		30. Name and address of person who co	0 - 6 1			Westmi	nictra	Mn 2	21157	
			SINU CHACKO 31. Date filed (Month, Day, Year)		ar's Signature	nue		, 100	- 9		
	Sta Registi		APR 1 2	2005	ar's Signature	how .	,				
					Man V.	Marine Co					

	ì		1 - For State Registrar		aryland / Dep <i>Ce</i>	artmen			d Mental H	ygier Reg. I	20	05	11.73
	Physici /Medi		1. Decedent's Name (First, Middle, La Robin Lynn Wa	•					2. Date of I Month April		Day 2005	Year	3. Time of Death  5:30 P
1	Examir		4a. Facility Name (If not institution, given Clearview Nursing  5. Social Security Number 6. S.	Home	(In yrs. last birthday	Hage	rsto	If Under 24 H	Irs. 8. Date of 8		4c. County Washi	ngto	n
	Director		178-48-1020 Usual Residence of Decedent  10a. State 10b. County	M 2□F	45 Yrs.	Months	Days	Hours M	lin. (Month, I			PA	place (State or Foreign
	is 1 and 2 should be filed within 72 hours after death with the Maryland if Heelint and Mental Hygiene. If Heelint and Mental Hygiene is the file and 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at	ai Director	PA Fulton  10e. Street and Number  168 Black Oak Ro	ad	Warfordst	ourg 101. Zip	code 267			10g. 0	Citizen of W		10d. Inside City Limits 1 ☐ Yes 2 No  ntry?
9	hours after dea tural', or items	Completed by Funeral Director	11. Marital Status  1   Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:	lo	1□Yes 2	2⊠ No	Specify:	(Specify Yes or f erto Rican, etc.)		Specify:	k, White,	White
21215-	d within 72 giene. r than "nat the Medic	omplete	15. Decedent's Elementary/Secondary (0-12)  12		+) (Give	edent's Usua e kind of wor DO NOT us dinate	k done di e retired)	tion <i>uring m</i> ost of u	working		Kind of Bu		<sub>dustry</sub> ufacture
Maryland ?	1 and 2 should be filed within 72 hours beight and Mental Hygiene. em 27 is merkad other than "natural", ther treumatic event, Ing Medical Era	To Be C	17. Father's Name (First, Middle, Last, Gilbert G. Ward					Mabe	Name (First, Midd e1 G. Sm.	ie, Maide ith	en Sumame	9)	
re, Mar	s 1 and 2 sh Heelth and Item 27 is m other treum		19a. Informant's Name/Relationship ( Dawn M. Grimm/Niec 20a. Method of Disposition		1280 20b. Place of Disp	1 El ]	Paso	Drive	Hagersto Date	own,	MD 21	742	
Baltimore,	permit. Pages Depertment of Importent: If It any Injury or o		Donation 5 □ Other (Specif	Method of Disposition    Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or Townsend									
	Physician Medical Medical was in particular with pricing and the priming the priming and the p	Icai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to for as a Due to for as a C.	the death. Do not ene.	ter the mode	of dying	, such as card					Approximate Interval Between Onset and Death CWONIC
P.O. Box 68	the death certific by the attending p ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the second of	Fetal death 3	⊒Ectopic pre ⊒ Other (spe					23d. Date Mont		o <b>ry</b> Day Year
ords, P	w requires that s been signed b should be deta	2	Part it. Other significant conditions of	ontributing to death bu	t not resulting in the u	indertying ca	use giver	in Part I.			use contrit		ably 4 Tunknown
		Completed							24a. Wa aut per 1 🗆 Yes	opsy formed?	de	ath?	osy findings available inpletion of cause of 2 No
ION OT VII	ang rnys h. After this funeral di	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Matural 5 Pending investigation	Hospital: 1 Inpatien  28a. Date of Injury (Month, Day	/ 28b. Time o		Other Ic. Injury a Work?	4 Tursing	Home 5 Res	sidence	6 Other		1)
É	in Diffe	Certification;	3 Suicide 6 Could not be determined	building, etc.					City or To	own, Sta	te)		Route Number,
:	ro me nospitel within 24 hours a To the Funerel completely filled	ledicai	one)	ysician: To the best of niner: On the basis of and manner stat	examination and/or in	vestigation,	in my opi	nion, death oc	ce, and due to the curred at the time	e cause( e, date ar	s) and man nd place, ar	ner as stand due to	ated. the cause(s)
)	with To	Σ	29b. Signature and title of certifier			D	DO 6	2223	3	29d. D	ate signed	(Month, E	Day, Year)
	Sta	10	30. Name and address of person who Vasant Datta, M. 31. Date filed (Month, Day, Year)	D. 340 Mil	1 Street H	lagers	town	, MD 21	L740		•		
	Registr		APR 2 9 2	32. <b>1</b> gistrai	UB A	carde.							

			For State Registrar	State o	of Maryland		artment rtificate			Mental Hy	giene Z	00	)   1	731
			1. Decedent's Name (First, Middle	e, Last)						2. Date of D Month		Vasa	3. Time of	f Death
	Physicia /Medic		Sarah	Jenette	Yee						18, 20	005 Year	3:15	5 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, To	own, or	Location of Deal	h	4c. Co	unty of Dea		
		•	St. Mary's	Hospital					nardtown		St	. Mary	/'s	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ■ F	7. Age (In yrs. In		If Under 1 Months	Year Days	If Under 24 Hrs Hours Min	(Month, D	lay, Year)	C	thplace (State o	or Foreign
	Director		236-22-4250 Usual Residence of Decedent		80	Yrs.				July 23	3, 192	4 (	)hio	
700	. A		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside C	ity Limits
2	fsh	ō	Maryland St. M	lary's			Ho1	1137	rood				1 ☐ Yes	2 No
<u></u>	288	Director	10e. Street and Number	ary 5			10f. Zip C		voou –		10g. Citizer	n of What Co	ountry?	
žį.	38 0		24635 Cougar Co	urt					20636		Unit	ed Sta	tos	
Ind 21215-0036 he filed within 72 hours after death with the Maryland	ms 2	Funeral	11. Marital Status		edent Ever in U.S	S. 13. \	Was Decede	nt of Hi	spanic Origin? (S n, Mexican, Puer	specify Yes or N		Race - Ame	erican Indian,	
9	or ite	Ē	1 ☐ Never Married 2 ☐ Marr		2 <b>N</b> o		res, specin 1 ☐ Yes 2		n, Mexican, Puer Specify:	to Hican, etc.)		Black, White Black, White Black, White		
93		d by	3 Midowed 4 □ Divorced	Year or D	ates:		10, 10, 28		эрвспу.		Sp	ecity: W1.	irre	
5-6	nate	Completed	15. Deceden (Specify only highes	t's Education at grade completed)		16a. Deced (Give	dent's Usual kind of work	Occupa done d	ation furing most of wo )	rking	16b. Kind	of Business	/Industry	
2	Pan a	mpl	Elementary/Secondary (0-12)	College (	1-4or 5+)	life. I								
2 2	tygie her t		10 17. Father's Name (First, Middle,	l act)		<del></del>	Cas	shie		me (First, Middle	Maidan Su	Banki	.ng	
anc	ad of	Be										mame)		
2	d Me nark natic	ဥ	Oran Bennet  19a. Informant's Name/Relations			10b Mailin	a Addross (	Stmota	and Number or R	enny Sut		Ctata	Tin Code)	
Ma	th and 7 is r			on			-						, ,	
م بو	Healt em 2		20a. Method of Disposition	OII	20b. PI	ace of Dispo	sition (Name	of	Court, He	Date			ZU030 Town, State	
jou se	ayes int of t: If if		1 Burial 2 Cremation		State	emetery, cren	,	•	1	2005				
Baltimore, Maryland 21215-0036	penium rages i rainz shouto be free within 72 hours and beau with the wayran beauthant of Health and Mental Highene. Important: if item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be rediffied at once.		' 4 □ Donation 5 □ Other (S		Bri		. Name and		Cr. 4-24				lall, MI	
Ba a	one one		Edward N. Brins	field, Jr		52 22	955 Hc	11y	wood Roa		nardtov		20650-	-0279
	*		23a. Part1, Enter the disease, or shock, or heart failure. List	complications that only one cause on a	caused the death each line.	. Do not ent	er the mode	of dying	g, such as cardia	c or respiratory a	arrest,		Approximat Interval Bet Onset and	ween
<b>b</b>	hysician		Immediate Cause (Final disease or condition Myolackal lutavctors											UZ.
	/Medical xaminer		resulting in death)	Due to	(or as a consequ	ience of):			1					
	.xammer	_	Sequentially list conditions,	b	(or as a consequ									
70	lsit a	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C Due to	(or as a consequ	ience oi):								
y XACII	al-trar	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a consequ	ience of):								
8760,	physician and the burial-transit	dicai E		<b>.</b> .										
	phy:	. ຜ ⊦		u										
	ned by the attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnar		le				23d	. Date of del	livery	
P.O. Box	de atte	icia	in the past 12 months? 1 ☐ Yes 2 🕱 No	4□Pregr	oirth 2 Tetal nant at time of de		]Ectopic preg ] Other (s <i>pe</i> c					Month	Day	Year
O. E	by th	hys	9 □Unknown	9□ Unkn	own									
S, F	igned be del	ру Р	Part II. Other significant condition	ons contributing to d	eath but not resu	ulting in the un	nderlying cau	ise give	en in Part I.	23e. Did	tobacco use	contribute to	the cause of d	leath?
ord	been si									1 🗆	Yes 2□N	lo 3 Pr	obably 201	Unknown
Vital Records,	as be	Completed								24a. Was	s an 2	4b. Were at	topsy findings	available
	ate h	Son								perf	ormed?	death? 1 ☐ Yes	~	
of Vita	s certificate has birector, page 2 s	Be (	25. Was case referred to medical examiner?						26. Place of De	ath (Check only	опе)			
of V	his co	2	1 ☐ Yes ÆXÎNo			ER/Outpatien	t 3□ DOA	Othe	Pr: 4 ☐ Nursing H	lome 5 Res	idence 6	Other (Spe	cify)	
	After this funeral di	on:	27. Manner of Death 1 Matural 5 ☐ Pendin	9	of Injury th, Day Year)	28b. Time of Injury		. Injury Work	:?	28d. Describe	how injury or	curred		
Vision	seath tor: /	cat	Z Accident investig 3 Suicide 6 Could	not be	-//		М		fes 2 □ No	006 11	(0)			
Division	after death Director: I in by the	Certification:	4 Homicide determ	ined 200. Flace	of Injury - At hor ing, etc. (Specify	me, farm, str	eet, factory, o	office			(Street and N wn, State)	umber or Hi	ural Route Num	ber,
	erel i		29a. Certifier Certifyin	g Physician: To the	hoet of my know	wodan doath		the time	a data and place	and due to the		-		
H	24 ho Fun stely	edicai	(Check only 2 Medicel one)	Examiner: On the b	asis of examination	ion and/or inv	estigation, in	n my op	inion, death occi	rred at the time,	, date and pla	a manner as ice, and due	stated. to the cause(s	:)
To the Hosnital	of the Transplace of Atlanta Brigarian. The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Me	29b. Signature and title of certifie				29c. l	License	number		29d. Date si	gned (Mont	h, Day, Year)	
			Dia IM	ain	MD		B	47	093		Ann	1 10	700	5
- 5	S/A-0		30. Name and address of person	who completed caus	se of death (Item	23a) (Tvpe		` '			TIPL	1 13	1 000	
	3		DR. MARTIN MO	CREIVY				ים חק	r OFFICE	BUA EU	7 TEOM	A Domor	INI NO	2065
	Sta	te	31. Date filed (Month, Day, Year)	32. F	Registal's Signat	ure A		.va.	L VEELUE	_DUA_3Z.	- LEQN	4KD TO∤	viv , MD	40650
	Registr	ar	APR	Z 1 Z005)	Registal's Signat	, B	Laces							

		í	For State	State of M	Maryland .		artmen rtificate			ind M		< U	05	14739
			Registrar  1. Decedent's Name (First, Middle, Last	<u> </u>			timout	0 07 2	Journ		2. Date of Dea	th		3. Time of Death
	Physici		Charles Georg	re Adams							Month April	19, 200	Year	5:30 PM M
	/Medic Examin		4a. Facility Name (If not institution, give		r)		4b. City,	Town, or	Location of	f Death	219121	4c. County		
			16 Carver Str	eet				Anna	polis			Anne	Arun	ide1
	Funeral		Social Security Number     6. Se		Age (In yrs. last	birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Sept 1,	Year	9. Birth	place (State or Foreign intry)
	Director		213-12-8030	M 2□F	85	Yrs.	WIOTITIS	Days	110013		Sept 1,	T919	Mary	land
	pus *		Usuel Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City Limits
	Aaryti r sho	ō	MD Anne Aru	ındel		napo								1 ☐ Yes 2X No
	28a-	Director	10e. Street and Number				10f. Zip	Code			1	Og. Citizen of	What Cou	intry?
	with 3a or		16 Carver Street				1011.00		1401			US		,
	The 2:	era	11. Marital Status	12. Was Deceder	t Ever in U.S.	13.	Was Deced			jin? (Spe	cify Yes or No- lican, etc.)			icen Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or Iteme 23a or 28a-f show or other traumatic event, it a Medical Exaction traumatic event, it a Medical Exaction traumatic event.	by Funeral	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces  1 X Yes 2 [ If Yes, Give Year or Dates			lf Yes, spec 1 ☐ Yes :		n, Mexican, Specify:	Puerto F	lican, etc.)	Specif	ck, White y: 1	, etc. black
ŏ	2 ho	Completed	15. Decedent's Edi	ucation		6a. Dece	dent's Usua	I Occupa	ation	-4		16b. Kind of B	usiness/lr	ndustry
215	e. e. m. r	pie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	DO NOT us	e retired	luring most )	or workin	g			
2	od wil	50	12	0		mess	enger	<u> </u>				ba	nking	3
D	al Hy	Be (	17. Father's Name (First, Middle, Last)						18. Mother	r's Name	(First, Middle,	Maiden Suman	ne)	
yla	should be ind Mental I	2	Charles Edward						Her	riet	ta Herb	on		
Maryland 21215-0036	alth and 25 is made 27 is more readmand 37 is		19a. Informant's Name/Relationship (T) Lillian Brown/nic			19b. Mailir	ng Address	(Street a	and Number	r or Rural	Route Number	r, City or Town,	State, Zij	o Code) unk
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 ie any injury or other trae		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I 14 ☒ Donation 5 ☐ Other (Specify,		com	e of Dispo etery, crer	sition (Nam natory or o	ne of ther place	9)	Da	ate	20c. Location	- City or T	own, State
Balt	permit. Departr Importu		21. Signature of Funeral Specificens	Wade Di	tor	St	Name an Late A	Anato	s of Facility Omy Bo MD 2	, pard 21201	655 W.	Baltim	ore S	Street
*			23a. Part1. Enter the disease, or composhock, or heart failure. List only of									est,		Approximate Interval Between
<b>≱</b> -164	Physician		Immediate Cause (Final disease or condition	a/2	heim s a consequent e mia	ner's	De	me	ntic	7				Onset and Death
	/Medical		resulting in death)	Due to (of a	is a consequen	ice of):			7.					
Ц	Examiner		Sequentially list conditions,	b. And	2 mia	, ut	1 kno	run	etio	loge	-			
	pa tis	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	is a consequen	ice of):				0 (	,			
	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c	is a consequen	ce of):								
8760,	be exicient	a E	l l											
687	icate phys s the	dicai	<u> </u>	d										
Вох	eath certific attending p I for use as I	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								23d. Da	te of deliv	erv
	d for	cial	in the past 12 months?	4☐Pregnant	2 ☐ Fetal de at time of deatl		Ectopic pro Other (sp.						onth	Day Year
o O	t the c by the acher	hys	9 Unknown	9□ Unknown										
	requires that the de been signed by the s should be detached	y P	Part II. Other significent conditions co	ntributing to death	but not resulting	ng in the u	nderlying ca	ause give	n in Part I.		23e. Did tol	pacco use cont	ribute to t	he cause of death?
ğ	w require been sig should b	ed	Cerebrovascu	lar Ho	eider	275					1 □ Ye	s 2 No	3 ☐ Prol	bably 4 ⊠Unknown
Records,	aw re	Completed									24a. Was a	n 24b.	Were auto	opsy findings available ompletion of cause of
	The ate has page	E									perform	ned?	death?	2⊠ No
Vital	ian: rtifica ctor, p	Bec	25. Was case referred to medical						26. Place	of Death	(Check only on			
	nysic olis ce direc	ToE	examiner? 1 ☐ Yes 2 🖫 No	Hospital: 1 ☐ Inpa	tient 2□ER	/Outpatier	t 3□ DO	A Othe	F: 4 □ Nur	sing Hom	e 5 🖾 Reside	nce 6 □Oth	er (Specia	fy)
o uo	nding Pł th. : After tł s funeral	tion:	27. Manner of Death  1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D	jury 28 Pay Yeer)	b. Time of Injury	f 2	8c. Injury Work 1 🔲 Y	at ? (es 2 🗆 N		8d. Describe ho	w injury occur	red	
Division of	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filed in by the funeral director, page 2	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I building,	njury - At home etc. (Specify)	, farm, str	eet, factory	, office		2	8f. Location (St City or Town	reet and Numb n, State)	er or Rura	al Route Number,
	he Hospit n 24 hour he Funera pletely fille	Medical (	29a. Certifier 1 ☑ Certifying Phy (Check only one) 2 ☐ Medical Example (Check only one)	rsicien: To the bes iner: On the basis and manner:	of examination	dge, deatl and/or in	occurred vestigation,	at the tim in my op	e, date and inion, death	l place, a h occurre	nd due to the ca d at the time, d	ause(s) and ma ate and place,	anner as s and due t	stated. o the cause(s)
)	To the To the comp	Σ	29b. Signature and title of certifier  Nancy D Ricu	na King	g, 130.		29c	D 00	number 4090	4 6	tary line	9d. Date signer	d (Month, 25)	Dey, Year)
			30. Name and address of person who c	liever	N		the	patt	Avi	lle	m	d =	201	181
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 2 2005	32. Regis	strar's Signature	food	را	1						

1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Personal	Wildows and	~7	L	
3.	Time	of E	Death	1

0521

10d. Inside City Limits

Interval Between Onset and Death

Year

Day

29d. Date signed (Month, Day, Year)

2515

Ave Baltimo

1√Yes 2□No

Physician
/Medical
Examiner

**Funeral** Director

72 hours after death with the Maryland item 27 is marked other than "netural", or items 23a or 28e-f show other traumatic event, the Medical Exercipant results be rotilized at 3.2 should be filed within 7. h and Mental Hygiene." 7.1s marked other than "n. permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is rr any injury or other traum once.

Jaimes Arrington

**Physician** /Medical Examiner

use as the burial-transit certificate be executed and attending physician Division of Vital Records, P.O. Box 68760, been signed by i Hospitel or Attending Physician: After this funeral within 24 hours after death. To the Funeral Director: A

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month, Year James Arrington 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Baltimore Baltimore Sina If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0ct 19, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1⊠M 2□F 212-56-4790 61 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. Count Completed by Funeral Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4017 Liberty Heights Avenue 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ੴ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) labor construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wilson Arrington Cherry Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosetta Jones/sister 3117 Sequoia Avenue Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 💆 Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Styneture of Funeral Stylice Director 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Artenoselerate caranvescalardisesse disease or condition resulting in death) Due to (or as a consequence of) Hipertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner 12 In Sufficience that initiated events resulting in death) Last Due to (or as a consequence of): pneumonis Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Caraco-pulmenen 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 又Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 12 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 🗌 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

Registrar

31. Date filed (Month, Day, Year) MAY 0 2 2005



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the

29c. License number

030115

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical cility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Balhmore Johns HOPKINS BAYVICU Balhmore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov 20, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**∑**M 2□ F 052-03-5042 89 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State unk 10b. County 10c. City, Town or Location unk 10d. Inside City Limits orient: If item 27 is marked other than "neturel", or items 23e or 28a-1 show injury or other treumatic event, the Mactical Examinators and injury or other treumatic event, the Mactical Examinators and injury or other treumatic event, the Mactical Examinators and injury or other treumatic event, the Mactical Examinators and injury or other treumatic events. unk1 🗆 Yes 2 🗆 No Director unk unk 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: white 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk unk permit. Pages 1 and 2 should be I Department of Health and Mental I Importent: If item 27 Is marked o 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johns Hopkins Bayview 4940 Eastern Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State '4 □Donation 5 MOther (Specify) in State 21. Squature of Funeral Server Sicenses Wade, Director State Anatomy Board 655 W. Baltimore Street any in nuc Baltimore, MD 21201 comflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Enter the disease, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia ASDIVATION **Physician** days /Medical Due t (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE nse. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate b 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 HNatural Injury 1 ☐ Yes 2 ☐ No 2 Accident "investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ADVII 20, 2035 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EUSHIN ARINUC, BUIHMAR, MD 2122 rdan DR - TYNECHÎ A 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005

		1 - For Stete Registrer	State of Maryla		artment of I rtificate of			iene <sub>eg. No</sub> 200	5 1474
Physici /Medic	al	1. Decedent's Name (First, Middle, Last)  Margaret S. Bu			At Ch. T			0, Day 2005 Ye	
Examin	er	4a. Facility Name (If not institution, give s Keswick Multi	Medical		Baltimo			4c. County of D	
Funeral Director		5. Social Security Number 220-10-4273 6. Sex	M 2\\ F\ 90	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Mar 28,	<sup>Y</sup> ear) 1915 M	Birthplace (State or Fore Country) laryland
Ba-f show	ector	10a. State 10b. County MD	10c. C	ity, Town or Lo Balt	cation Cimore				10d. Inside City Lim 1 🎇 Yes 2 🗆 I
h with th	al Dire	10e. Street and Number 700 W. 40th Street	et		10f. Zip Code	1211	1	0g. Citizen of What USA	Country?
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I Health and Mental Hygiene. I fem 27 Is marked other than "naturel", or items 23s or 28s-f show other treumatic event, the Madical Examinar must be mortlind at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of Information of Info	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, thite, etc. white
ithin 72 ho ie. ien "natur i Medical I	Completed	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of wor	king	16b. Kind of Busine	ss/Industry
2 should be filled withir and Mental Hygiene, Is marked other than eumatic event, the Ma	Be	12 17. Father's Name (First, Middle, Last) John Goshorn She	4		housewi	18. Mother's Nam	ne (First, Middle, A		ne
2 should be fand Mental His marked of sumatic eve	၉	19a. Informant's Name/Relationship (Type	ne, Print)	19b. Mailin	g Address (Street		Letta HO1 ral Route Number,	City or Town, State	e, Zip Code)
1 and 2 Health em 27 I		Keswick Multi Medi		100	W. 40th	Street E	_	, MD 2121	
Page nent o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☑ Donation 5 ☐ Other (Specify)	amoval from State	cemetery, cren	natory or other pla				
permit, Departn Importe any Inju		21. Signature of Funeral Service License Ronal of Service License	d 655 W. 01	Baltimor	e Street				
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ie be executed ysician and e burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect	235					
The law requires that the death certifical attending the attending phy attending phy age 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of of 9 Unknown	aldeath 3□	Ectopic pregnancy Other (specify)	,		23d. Date of o	delivery Day Year
quires that in signed build be deta	þ	Part II. Other significant conditions cont	ributing to death but not res	sulting in the un	derlying cause giv	en in Part I.			to the cause of death?
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To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	<b>(y</b> )			City or Town,	State)	Rural Route Number,
4 hou	edicai	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examina	cian: To the best of my known:  On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and manner te and place, and di	as stated. ue to the cause(s)
vithin 2-	Me	29b. Signature and title of certifier  MMOTULE	This		29c. License	9 number 2 4 3 3		d. Date signed (Moi	
		30. Name and address of person who con MOHCY MO		n 23a) (Type, F	Print)	±5 S1	BMT,	MGKE"	mn 2120
Stat	e	31. Date filed (Month, Day, Year)  MAY 0 2 2005	32. Registrar's Signa			,			

Please	e Type or	Print in E	Black In	delible Ink.	Ensure A	II Copies	Are Legi	ible.			
	State of	of Marviar	d / Depa	artment of H	lealth and N	nental Hv	aiene.				
		,		rtificate of			Reg. No.	05	14743		
(First, Middle, I	Last)					2. Date of De	eath Day	Year	3. Time of Death		
N LEI	E WATT	ES BL	AND			MAY	1,20	005	2:33AM		
not institution, g	give street and nu	ımber)		4b. City, Town, o	r Location of Death		4c. County	of Death			
SAMAR	ITAN	HOSPI	TAL	BALT	TIMORE		N/	A			
mber 6	1. Sex 1	7. Age (In yrs. <b>7</b> 2		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 11/08	y, Year)	Cour	place (State or Foreign htry) GINIA		
Decedent											
10b. County		10c. Cit	ty, Town or Lo	ocation				1	10d. Inside City Limits		
N/A		В	ALTIM	ORE CIT	Y				¹X Yes 2 □ No		
per				10f. Zip Code			10g. Citizen of	What Cour	ntry?		
PRING	DALE AV	ENUE		21	207		USA				
d 2 Married	Armed F	2.X No ive		Was Decedent of Hilf Yes, specify Cubin	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		ck, White,	can Indian, etc. ACK		
15. Decedent's y only highest	Education grade completed,	)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	king	16b, Kind of B	usiness/In	dustry		
dary (0-12)	_	(1-4or 5+)	HOME		•	7D	SELF-	EMDT (	OVED		
irst, Middle, La		ARS	TIONE	IIDADIII	18. Mother's Nam				OIED		
WAITI					MUR		AITES	,			
*****	_ ~				MATIES MATIES						

12TH 17. Father's Name (F HARVEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4401 SPRINGDALE AVE. STACEY HENDRICKS / DAUGHTER BALTIMORE, MD 21207 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition MD VETERANS CEM. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 5/6/05 OWINGS MILLS, MD 21. Signature 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): PNEUMONIA Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify)

**Physician** /Medical Examiner

For State Registrar Decedent's Name

4a. Facility Name (If

224-38-0

Usual Residence of I

10e. Street and Num

11. Marital Status 1 Never Marrie

4401 S

3 X Widowed 4

(Specif Elementary/Secon

☐ Yes ☐ No

25. Was case referred to medical examiner?

1 Yes PNo

27. Manner of Death

Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

9 Unknown

MD

10a. State

600D 5. Social Security Nu

AN

**Physician** /Medical

Examiner

Directo

Completed by Funeral

Be

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**Funeral** 

Director

72 hours after death with the Maryland

f Health and Mental Hygiene. item 27 Is marked other then "naturel", or Items 23a or 28a-f shov other treumetic event, I'm Me.Jical Examir at must be notified at

s 1 and 2 should be fill Health and Mental H tem 27 Is marked ott

Pages nent of H ent: If ite

permit. Page Department of Importent: If any injury or once.

Examine -transit Completed by Physician/Medical Be ů

The law requires that the death certificate be executed the as To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica After thi funeral after death.

Director: Af
d in by the fur

Certification Medicai

State Registrar

29b. Signature and title of certifier

9 Unknown

RENAL FAILURE

Hospital:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

P15306

Lycrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

5/01/05 HOSPITAL

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

24a. Was an autopsy performed?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

1 ☐ Yes 2 No

28d. Describe how injury occurred

1 Yes 2 No 3 Probably Lonknown

1 Tyes

24b. Were autopsy findings available prior to completion of cause of death?

2 🗆 No

ted cause of death (Item 23a) (Type, Print) GOOD SAMARITAN GILBERT BOURJEILY , S601 LOCH RAVEN BLVD, BALTIMORE, MDZ1Z39 31. Date filed (Month, Day, Year) 32. Registrar's Signature

MAY 02 2005

5 Pending investigation

6 Could not be determined

☐ Impatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

			State of Maryland / Department of Health and Mental Hygiene 11 711	
			For State of Maryland / Department of Fleath and Mental Trygleng (15)	L
	Physici /Medic Examir Funeral Director	cal	1. Decedent's Name (First, Middle, Last)  2. Date of Death Amonth Pay Year 7. 3. Time of Death Amonth Pay Year 7. 3. Time of Death Amonth Pay Year 7. 3. Time of Death Amonth Pay Year 7. 3. Time of Death Amonth Pay Year 7. Age (Inflyrs. last birthday) 1. Social Security Number 2. Date of Death Amonth Pay Year 4c. County of Death Amonth Pay Pay Pay Pay Pay Pay Pay Pay Pay Pay	1
	e Maryland Be-f show	Director	Usual Residence of Decedent  10a. State	
	3a or 2	i Dire	10e. Street and Number 7548 Old Telegraph Road 10f. Zip Code 10g. Citizen of What Country? USA	
920	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itams 23a or 28e-f show ther than madical Exemities out be notified at	by Funeral	11. Marital Status  1	
Maryland 21215-0036	d within 72 ho giene. or than "natur Itse Modical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  College (1-4or 5+) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Manager  16b. Kind of Business/Industry H.J. Heinz Co.	
yland	ld be ental ked o	To Be (	17. Father's Name (First, Middle, Last)  Stephen Joseph Berberich  18. Mother's Name (First, Middle, Maiden Sumame)  Minnie J. Esposito	
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Type, Print)  Mr. Steve Berberich / son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  P.O. Box 652 Waldorf, MD 20604	
Baltimore,	permit. Pages 1 and 3 Department of Health Important: if item 27 any injury or other tr. 2008.		20a. Method of Disposition  1 \( \times \) Burial 2 \( \times \) Cremation 3 \( \times \) Removal from State  1 \( \times \) Donation 5 \( \times \) Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Loudon Park Cemetery 4/30/2005  Baltimore, MD	
Ball	permit. Departr Importi any inji		21. Signal re of Funeral Service Licensee M01364  22. Name and Address of Facility Singleton Funeral Home P.A.  1 Second Ave SW Glen Burnie MD 21061  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate	
760,	/Medical Examiner	ical Examiner	23a. Part T. Enter the disease, or complications that a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
.O. Box 68	The law requires that the death certificate be execufed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   9   Unknown	
Δ.	w requires fhat i been signed by should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes   2   2   2   3   2   2   3   2   3   2   3   2   3   3	ΝΠ
Il Records,		Completed	Ea, lurge to this completion of cause of autopsy performed?  1 Yes 2 No	ole of
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1   Ves   2   No	
of	on.	ation: To	27. Manner of Death 1 New Tural 5 Pending 2 Accident investigation 2 28a. Date of Injury 1 New Tural 5 Pending investigation 2 28b. Time of Injury 2 New Tural 5 Pending investigation 2 28b. Time of Injury 4 Nork? 1 New Tural 5 Pending investigation 2 28b. Time of Injury 4 Nork? 1 New Tural 1 North Park Tural 2 28b. Time of Injury 4 Nork? 1 New Tural 1 North Park Tural 2 28b. Describe how injury occurred 4 Nork? 1 North Park Tural 2 28b. Describe how injury occurred	
Division	tel or Attend is after death al Director: , ed in by the f	Certification:	3 Suicide 6 Could not be determined 4 Homicide 6 Could not be determined 5 Real Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, lactory, office City or Town, State)	
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical	29a. Certifier  (Check only one)  1 Gertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
)	S Wild	2	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  1014753 N. 4/26/07	
0	21		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  98 Quakut Dock (Clem 23a) (Type, Print)	
	Sta Regist		31. Date liled (Month, Day, Year) 3. Registrar's Signature (MAY 0.2. 2005	

			For State		of Maryland / De		Health and M		~	W 40 40 40 40 40 40 40 40 40 40 40 40 40
			Registrar  1. Decedent's Name (First, Mid	Idle ( set)		eruncate of	Dealii		eg. Nof U U J	14/40
	Physic		Margaret			77		2, Date of Deat Month	Day Year	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institut	LOUIS		Broat 4h City Town	or Location of Death	April 2	6, 2005 4c. County of Dea	7:25 pm M
	LAGIIII	ici	Augsburg Luth		,				4c. County of Dea	ui i
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birtho		NOTE r If Under 24 Hrs.	8. Date of Birth	9. Bir	tholace (State or Foreign
	Director		217-26-4644	1 □ M 2 💢 F	99 Yrs	Months Days	s Hours Min.	(Month, Day, August	Year) C	rthplace (State or Foreign ountry) 7irqinia
	pu "		Usual Residence of Decedent					71agase	17 1305 (	/iiginia
	aryla ehov	_	10a. State 10b. Coun	ту	10c. City, Town o	r Location				10d. Inside City Limits
	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If itam 27 is marked other then "natural", or items 23a or 28a-f ehow or other traumatic evant, the Medical Examinations required.	Completed by Funeral Director		timore	Essex				<u> </u>	1 ☐ Yes 2 X No
	with t		10e. Street and Number			10f. Zip Code		11	0g. Citizen of What C	ountry?
	s 23	srai	2408 Bauernso		cedent Ever in U.S.	21221			U. S. A.	
	Item Item	Ľ,	11. Marital Status 1 Never Married 2 M	Armed F		If Yes, specify Cul	Hispanic Origin? (Spe ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
336	ir, or	by F	3X Widowed 4 □ Divorce	If Vac C	ive	1 ☐ Yes 2🛣 No	Specify:		Specify:	r.d. ' 1
21215-0036	2 hou	ted	15. Deced	ent's Education	16a. De	ecedent's Usual Occu	upation		16b. Kind of Business	White
215	hin 7	pie	(Specify only high Elementary/Secondary (0-12	est grade completed	) (G (1-4or 5+)	ive kind of work done e. DO NOT use retire	eduring most of working)	ng	. ob. Talle of Egginosa	andustry
2	d with giene. er thar	NO.	12	College		memaker			Own Home	
P	ould be filed Mental Hygiarked other artic evant, II	Be (	17. Father's Name (First, Middle	e, Last)			18. Mother's Name	(First, Middle, M		
/la	should but marked	10	Richard Hugh	Griffith	1		Mary V	Valker		
Maryland	2 sho and I is me		19a. Informant's Name/Relation	nship (Type, Print)	19b. M	ailing Address (Stree	t and Number or Rura	l Route Number,	City or Town, State,	Zip Code)
	permit. Pages 1 and 2. Department of Health ar Important: If Itam 27 is any injury or other traugones.		_Nancy Irma St	okes (Daug		18 Hiss Av	enue Park	ville.	Maryland 2	21234
Baltimore,	of Ho		20a. Method of Disposition  1   Burial 2 □ Cremation	3 DRemoval from	20b. Place of Di cemetery,	sposition (Name of crematory or other pla	D	ate 2	0c. Location - City or	
Ě	Pages ment of I ant: if its ury or o		*4 □ Donation 5 □ Other	(Specify)	Gardens	of Faith	Cem. 200	30 5 B	altimore,	Marvland
alt	permit. Departr Importa any inj		21. Signature of Funeral Service	e Licensee	1.0	22. Name and Addr	ess of Facility			- Lori y Lori Co
_	2 Q F # 9		Michael	C. Jaki	isa Sr.	1407 Old	ki Funeral Eastern Av	. Home PA Tenue Es	A ssex. Marv	land 21221
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that st only one cause on	caused the death. Do not each line.	enter the mode of dy	ing, such as cardiac o	r respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		A /	Demention				Onset and Death
	/Medical		resulting in death)	a Due to	(or as a consequence of):					
	Examiner		Sequentially list conditions	b						
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. [Leads 3 f ] ury that initiated events	Due to	(or as a consequence of):					
	ecute ind trans	Examiner	that initiated events	c						
,092	te be executed ysicien and te burial-transit	Ë	resulting in death) Last	Due to	(or as a consequence of):					
876	A × a	licai		d.						
к 68	entific ling p	Med	IF FEMALE:		-					
Вох	The law requires that the death certification has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?		tcome of pregnancy birth 2 Fetal death	3 □Ectopic pregnanc	:y		23d. Date of deli	,
0.	at the de by the a tached f	/sic	1 ☐ Yes 2X No 9 ☐ Unknown	4□Preg 9□Unkr		5 Other (specify)			Month	Day Year
<u> </u>	that the		Part II. Other significant condit	ions contributing to	eath but not reculting in the	. underheine eeure	in Double	OD- Didash		
ds,	signe signe	lby	artin outer organicality contain	ions continuently to c	eath out not resulting in the	a underlying cause giv	ven in Part I.		acco use contribute to	
0	w requir been si should	etec				·		1 1 105	2 NO 3 PR	obably 4 Stinknown
Records,	elaw hast	Completed						24a. Was an autopsy	prior to c	topsy findings available completion of cause of
<u> </u>		Co						perform	ed? death? ZNo 1 ☐ Yes	2 No
Vital	sician: T certificat rector, pa	Be	25. Was case referred to medic examiner?	Hospital:			26. Place of Death	(Check only one	)	
of	Phys this aldi	2	1 Yes 2 XNo	1	Inpatient 2 ER/Outpat	IBITE 3 DOA			ce 6 Other (Spec	city)
n	ding f h. After tuner	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pend	ing .	of Injury th, Day Year) 28b. Time Injury	/ Wo		8d. Describe how	injury occurred	
<u>isi</u>	ten Jeat tor: the	icat	3 ☐ Suicide 6 ☐ Could		attainer Akkens t		Yes 2 No			
Division	i or Atteno efter deatl Director:	ertif	4 Homicide deter	nined 286. Place build	of Injury - At home, farm, ing, etc. (Specify)	street, factory, office	2	8f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospitei or At within 24 hours efter or To the Funerei Directompletely filled in by		29a. Certifier 1 X Certify	na Physician, Tath	heat of my knowledge de-					
	Hos 24 hr Fun stely	edicai	(Check only 2 Medica	Examiner. On the D	best of my knowledge, de asis of examination and/or ner stated.	ath occurred at the til investigation, in my o	me, date and place, a opinion, death occurre	nd due to the cau d at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title of certifi		nor stated.	29c, Licens	se number	290	d. Date signed (Month	Day Yearl
	r s r ŏ		10	With- MD			7683	230	11-1	, _ <del> j</del> , · - <del> j</del> ,
	.\		30. Name and odress of person		co of death (from 00-1 /*				4127/05	
	Y\		Rumord Miller	25 Muis	Storet Suits 3	P	hislam, MD			
	Sta	te	31. Date filed (Month, Day, Year	) at 32. F	egistrar's Signature	ius ius	rusiawa 1710			
	Registr		MAY 0 2 20	105 Levens	egistrar's Signature	W.				

			1 - For State Registrar	State of Maryla	and / Depa		lealth and		_	ne.	I want to
	Physic /Med Exami	ical	1. Decedent's Name (First, Middle, Last, Sophi 4a. Facility Name (If not institution, give	,	Bied	rzyck 4b. City, Town, or Batt	00000	2. Date of Death Month	_	200S	3. Time of beath (
	Funeral Director		5. Social Security Number 6. Set 217-03-1637 10  Usual Residence of Decedent	x 7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Year)	9. Birthplac Country Maryl	ce (State or Foreign and
	ne Maryta Ве-f show diffied at	ctor	Maryland Balti		City, Town or Lo	cation	Dund	alk		10d	. Inside City Limits 1 ☐ Yes ※X No
	23e or 2	Funeral Director	1701 Stokesley R	toad		10f. Zip Code	21222	10	g. Citizen of Wi United		
9600	be filed within 72 hours after death with the Maryland hal Hygiene. In thygiene control, or tems 23e or 28e-f show event, the Malfall Exchibit with the Alfall Exchibit with the Alfall Exchibit with the Malfall With the Malfa	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 No	ispanic Origin? ( in, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		- American White, etc Wh	
21215-0036	filed within 72 h Hygiene. Ither then "netten", I're Medica	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 5 Years	cation e <i>completed)</i> College (1-4or 5+)	(Give life. I	lent's Usual Occupa kind of work done of DO NOT use retired	ation during most of we )	orking	6b. Kind of Bus		try
Maryland 2	should be filed ind Mental Hyg i marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) Paul Benevicz				Jozfi	me (First, Middle, M a Kojhansl	aiden Sumame, <i< td=""><td>)</td><td></td></i<>	)	
	and 2 ; ealth ar n 27 Is		19a. Informant's Name/Relationship (Ty, Mr. Richard C. Mik	ulski (Son)	98	Surrey La	ane Bal	dural Route Number, timore, Ma		tate, Zip Co 212	
Baltimore,	t. Pages tment of tent: If it		20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)  21. Stature of Funeral Service License	Sa	cred Ht		ıs Cem.	4/30/2005		alk,	Maryland
Ä	permii Depermii Impon any ir	-	23a Part. Enter the disease, or compli	cations that caused the de		7922 Wise	Ave. I	Home of I Dundalk, M	laryland	212	222
	Fhysician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	ial in	farcho	y, such as cardia	c or respiratory arres		Oi Oi	pproximate lerval Between nset and Death
8760, 7	cate be executed  bhysician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):	vry dis	lase			Y	ears
. Box 6	death certifie e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3 🗌	Ectopic pregnancy Other (s <i>pecify)</i>			23d. Date of Month	-	y Year
ords, P	The law requires that the de ate has been signed by the page 2 should be detached	ted by P	Pag II. Other significant conditions con		esulting in the un	1 1	n in Part I. Coronal		cco use contribu	ute to the c	\ /
	2 2 2	Completed by	artery disease, h	yperlipide	mia, h	ixperter	1510n	24a. Was an autopsy performe	prio dea	re autopsy r to comple th? Yes 2	findings available ation of cause of
Division of Vit	To the Hospital or Attending Physicien: The inwitin 24 Hours atter death.  To the Funeral Director: Atter this certificate he completely filled in by the funeral director, page	ertification; To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: Inpatient 2[ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA Other	r: 4 🗆 Nursing H	ath (Check only one) Home 5 Thesidence 28d. Describe how		(Specify)	
Divis	itel or Attars rs after de el Directo ed in by ti	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, stre ify)	et, factory, office		28f. Location (Stree City or Town, S	at and Number ( State)	or Rural Ro	ute Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier Check only one) Certifying Physical Examin	ician: To the best of my kn er: On the basis of examin and manner stated.	owledge, death ation and/or inve	occurred at the time estigation, in my opi	e, date and place inion, death occu	, and due to the caus irred at the time, date	se(s) and manne and place, and	er as stated due to the	l. cause(s)
1	Som Total	N.	29b. Signature and title of certifier	Yealna	n BM	29c. License	number 25-0	00 A	Date signed (A	Month, Day,	Year)
	1		30. Name and address of person who don 31. Date filed (Month, Day, Vear)	appleted cause of death (Ite	1940 E	castern	Avenu	Battin	roce, 1	ID.	21224
	Sta Registr		MAY 0 2 2005	See the solid soli	foods	•					

David Scott Bedsworth Jr 05-2911 AKG

			For State Registrar	State of M	larylan		artment o			and M	-	gien Reg. N	**	
	Physic /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> David Scott Bedsworth Jr.				2. Date of Death Day Year April 27, 2005 2:38 A							3. Time of Peath 2:38 A
	Exami	ner	4a. Facility Name (If not institution, given I-695 Southbound  5. Social Security Number 6.5	@ Provide	nce R	oad ast birthday)	4b. City, To  TOWSO If Under 1	n Year	If Under	24 Hrs.	8. Date of Birt	th	c. County of Death Baltimor	e County
	Director		218-98-1986 Usual Residence of Decedent	1 <b>Ø</b> M 2□F	23	Yrs.		Days	Hours	Min.	Fébruary	<i>)</i> 20',	1982 Mar	ÿYand
	with the Maryland is or 28a-f show Los notified at	Director	Maryland Baltimor	e		r, Town or Lo Parkvil	le							0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	£ 23 ∰	rai Dir	9811 Harford Road				10f. Zip Co 2123	34					itizen of What Cour USA	
9036	after or Its	by Funerai	11. Marital Status  1 💢 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Test Yes 2 Test Yes, Give Year or Dates:	?	1	Was Deceden f Yes, specify 1 ☐ Yes 2 🌣	Cuban,	panic Orig , Mexican Specify:	gin? (Spe , Puerto l	city Yes or No- Rican, etc.)	-	14. Race - Americ Black, White, Specify: Wh	
21215-0036	C 2 24	Completed	15. Decedent's E (Specify only highest grants) (0-12) 10		5+)	(Give life. L	lent's Usual C kind of work of DO NOT use i Denter	done du	ion <i>ring</i> most	of workii	ng	16b. F	Construct	,
Maryland 2	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, ITE M 2006.	To Be C	17. Father's Name (First, Middle, Last David S. Bedsworth,						18. Mother Tina N		(First, Middle, SSina	Maider		1011
			David S. Bedsworth,			9811 Ha	arford R	load			Route Numbe Maryland		or Town, State, Zip .234	Code)
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special	y)	Hi 1	imetery, cren Itop Ser	sition (Name natory or othe "Vice Co	r place)		5/2/0	ate 05		ocation - City or To Ison Marylar	
Ball			21. Signature of Funeral Service Licensee Christina L. Hilton  22. Name and Address of Facility Leonard J. Ruck, Inc.  5305 Harford Road Baltimore Maryland  21214  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate											
8760,	Medical Examiner  (the bural-transit	dicai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause the Interview of the initiated events resulting in death) Last	one cause on each	o a consequ	e of):								Approximate Interval Between Onset and Death
O. Box 6	death certifi e attending   d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	déath 3□	Ectopic pregn Other (specif						23d. Date of delive Month	ry Day Year
rds, P	ires sign t be	by	Part II. Other significant conditions of	derlying cause given in Part I. 23e. Did tob					bacco use contribute to the cause of death? es 2 ⅨNo 3 ☐ Probably 4 ☐Unknown					
al Records,	The law ate has b page 2 st	e Completed	25. Was case referred to medical									sy med? 2 🗌 No	prior to con death?	osy findings available apletion of cause of
of Vital	를 는 F	ToB	examiner?  **XYes 2 \sum No  27. Manner of Death	Hospital: 1 ☐ Inpati		FVOutpatient 28b. Time of		Other:	4 □ Nurs	sing Hom		ence	<b>X</b> ⊠Other (Specify,	at scene
Division	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Da	y Year) 5 ury - At hor	oa a	5 <sup>M</sup>		s 2 [ <b>Z</b> ∳N	0	Location (Si	du	of Nu w or Bural	hicle Lident Boute Number, Parident Red
	To the Hospitel within 24 hours a To the Funerel I completely filled	edicai	29a. Certifier (Check only one)	ysician: To the best niner: On the basis o and manner st	f examinati	rledge, death on and/or inv	occurred at the estigation, in r	ne time, my opin	date and ion, death	place, ai occurre	nd due to the card at the time, d	ause(s) ate and	and manner as sta I place, and due to	ated. the cause(s)
	To the within To the comp	×	29b. Signature and title of certifier	nce-Pol	Oct s	~		.M.I					te signed ( <i>Month, E</i>	
	8		30. Pegne and address of person who	completed cause of c	leath (Item	23a) (Type, F		Str	ceet	Balt	imore,	Mar	yland 2	1201
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 2	32. R gistr	ar's Signatu	B A	market							

			1 - For State Registrar	State	of Mary	land / De	epartmer Certificat	nt of H	lealth a Death	and M	lental Hyg	iene 2	005	14748	
	Physici		Decedent's Name (First, Middle, Lecilia	Last)	· · · · · · · · · · · · · · · · · · ·	Cimino					2. Date of Death Month	h	3, 2005	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, contact Juseph	ive street and nu	mber)	Center	4b. City	Town, or	Location (	OWS	on	4c. Cou	inty of Death	imore	
	Funeral Director		5. Social Security Number 6 218-18-0795	Sex 1□M 2∏F	7. Age (li 81	n yrs. last birtho	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Birth April 22	<sup>Ye</sup> <b>19</b> 24	9. Birthpl Mary	ace (State or Foreign Mand	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene.	e Maryland ra-f show tiffed at	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimo	re	10	oc. City, Town o								od. Inside City Limits 1 ☐ Yes 2 💆 No	
	th with th	Funeral Director	10e. Street and Number 7720 Daniels Avenue						10	10g. Citizen of What Country? USA					
	ours after dea ral', or items	Þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	edent Eve orces? 2XXNo ve oates:				n, Puerto	(Specify Yes or No- orto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White				
Maryland 21215-0036	d within 72 ho giene. er then "netu. . It e Mudical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) Coilege (1-4or 5+)  Homemaker					d of work done during most of working NOT use retired)					16b. Kind of Business/Industry Own Home		
land	uld be file Aental Hy rked othe tic event.	To Be C	17. Father's Name (First, Middle, La Henry Janowicz	st)						ors Name y Sied	e (First, Middle, M 11ak	faiden Sun	name)		
Baltimore, Mary	nd 2 shou alth and M 27 is mai		19a. Informant's Name/Relationship Kenneth Lee Cimino/	(Type, Print) 'Son		19b. M 1063	ailing Address	S (Street a	and Numbert Be	er or Rura   Air	al Route Number, Maryland	City or To 21014	wn, State, Zip	Code)	
	Pages 1 a ment of Hea ent: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spe			cemetery,	crematory or o	ther plac	(e)	5/2/05			on - City or Tov Maryland		
Balt	permit Depart Import any inj		21. Signature of Funeral Service Lic	PHIL	tina L ton	. Hilton	Leonard	J. Ri rford	ick, Ir Road	Yc. Balti	imore Mary	land	21214		
8760,	Medical Examiner  physician and burial-transit	ai Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If ally, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Co.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										Approximate Interval Between Onset and Death		
.O. Box 687	The law requires that the death certificate to has been signed by the attending physoage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									23d. Date of delivery Month Day Year			
S,	luires that signed by lid be deta	by									bacco use contribute to the cause of death? es 2No 3 Probably 4 Unknown				
I Record		Completed	CONGESTIVE HEART	FAILURE							24a. Was an autopsy perform 1 Yes 2	,	prior to com death?	sy findings available pletion of cause of	
Vita	Physician: this certificatal director, i	o Be C	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	Inpatient	2 □ EB/Outpa	itient 3 00	Othe	25.		(Check only one	f	Other (Checity)		
o	ding P h. After tl funera	-1	27. Manner of Death Natural Accident  5 Pending investigat		f 28c. Injury at Work? 28d. Describe				a how injury occurred						
DIVIS	Hospitel or Attend 4 hours after death Funerel Director: tely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not determine	ad 289. Place	of Injury ing, etc. (5	- At home, farm Specify)	, street, factor	y, office		1	28f. Location (Str City or Town,	eet and Nu State)	mber or Rural	Route Number,	
	To the Hospitel or Attenwithin 24 hours after deating the Funeral Director: completely filled in by the	edical	29a. Certifier 12 Certifying (Check only one) Medicel Ex	eminer: On the b	best of m asis of exa ner stated	amination and/o	eath occurred r investigation	at the tim , in my op	ne, date an pinion, dea	d place, a th occurre	and due to the cared at the time, da	use(s) and te and plac	manner as sta	ited. the cause(s)	
)	To the within 2 To the complete	W	29b. Signature and title of penifier	Foul	(1)	(		c. License			29	d. Date sig	29/05	ay, Year)	
	6		30. Name and address of person wh	o completed cau	1 05	FR DR	TUF. T	OWSF	IN. MC	78 AT	AND 213	2014	-1/		
	Sta Registr	1.0	31. Date filed (Month, Day, Year)	2005	Registrar's	Signature	porte								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 14749 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dav Year **Physician** Đ. OLA 2: 00 Pm 2-1505 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner Graal Stown
If Under 24 Hrs.
Hours Min.
8. Date of Birth
(Month, Day) altimore If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Months Days 1 □ M 2 🛛 F 7-22-1668 Director Usuet Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Menyland Department of Heelth end Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Exercises. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Maryland 1 Yes 2 No Funeral Director more 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 402 120 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give CX 14. Race - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 □ Divorced Year or Dates: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) tome d tra 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19a. Informent's Name/Relationship (Type, Print) daughte (-in 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 402 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) arme 22. Name and Address of Facility Joseph L. Rus 2222 WiNort 21. Signature of Funeral Service Licenses Home, P. A Kuss t unera WiNorth Ave 23a. Part. Enter the diffesse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and David Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical · HYPERTENSIVE CARDIUVASCULAR Examiner Due to (or es a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. Due to (or es e consequence of) Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown DEMENIIA Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? within 24 hours efter death.

To the Funersi Director: After this certificete hes I completely filled in by the funerel director, page 2 s t□Yes 3th No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) edicai Certification: To 1 Yes 2 No 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 27. Menner of Deeth 28d. Describe how injury occurred 1 Naturet 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Plece of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the ceuse(s) and manner es stated 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier D0059107 04-29-2005 MID 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 2.6 uv LIBERTY MEILINTS GROW STITIMORE, MO MEDICAL e. Segistrar's Signature 31. Dete filed (Month, Day, Year) 32. State

**DHMH 16 Rev 6/95** 

Registrar

0 2 2005

			1- For State of Maryland / Department of Health and I Certificate of Death		giene	5 14750						
	Physic /Med			2. Date of De Month	ath Day	3. Time of Death						
	Exami Funeral		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4b. City, Town, or Location of Death  4b. City, Town, or Location of Death  4b. City, Town, or Location of Death  4b. City, Town, or Location of Death  4b. City, Town, or Location of Death  4c. Ci	8. Date of Birt	th	of Death  A  9. Birthplace (State or Foreign						
	Director		Usual Residence of Decedent  1 M 2 F 71 Yrs. Months Days Hours Min.	07/37/1	933	Country) NY						
	ne Maryla 8a-f shov	sctor	10a. State 10b. County 10c. City, Town or Location COLUMBIA			10d. Inside City Limits 1 ☐ Yes 2 ☑ No						
	ath with t	Funeral Director	10e. Street and Number 10f. Zip Code 21046		10g. Citizen of W	·						
9800	within 72 hours after death with the Maryland ene. then "naturel; or Items 23s or 28s-f show its Medical Evartiner must be inclined at	by	3 ☐ Widowed 4 ፟፟ Divorced If Yes, Give Year or Dates:	pecify Yes or No Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. WHITE						
21215-0036	filed within 72 h Hygiene. Ither then "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  CHEMICAL ENGINEER		16b. Kind of Bus							
Maryland	1 and 2 should be Health and Mental Sm 27 is marked c ther traumetic eve	To Be	17. Father's Name (First, Middle, Last)  18. Mother's Nam  JULIUS  EPSTEIN  ANN	e (First, Middle,	Maiden Sumame H	ORSTEIN						
			19a. Informant's Name/Relationship (Type, Print)  JAIME  BUSSE  19b. Mailing Address (Street and Number or Rur  12401 ALEXANDER CORNE  20a. Method of Disposition  20b. Place of Disposition (Name of	LL DR.	FAIRFAX,	VA 22033						
Baltimore,	Page nent o ant: If ary or		1 🛣 Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  COLUMBIA MEMORIAL  04/29	/2005	20c. Location - C	, MD						
Ba	permit. Departr Importe any inje		8900 REISTERSTOWN R	MAD - P	IKFSVILL	E, MD 21208						
	Physician /Medical Examiner		23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. At Les Solvet Condition Due to (or as a consequence of):	or respiratory arr	rest,	Approximate Interval Between Onset and Death						
68760,	icate be executed physician and the burial-transit	Physician/Medical Examiner	dical	dical	dical	dical	<u>a</u>	ē				
P.O. Box 68	death certifi e attending id for use as								23d. Date o			
	sigr d be	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Chernatora Wthits			ute to the cause of death?						
Division of Vital Records,	The ate h page	Completed	Diabetes Mellitus	24a. Was a autops perform 1 Yes 2	y prio ned? dea	re autopsy findings available if to completion of cause of th? Yes 2 \sum No						
f Viit	Physician: this certifica ral director, p	To Be	25. Was case referred to medical examiner?  1  Yes 2 No			Speciful						
sion o	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certification plately filled in by the funeral director, completely filled in by the funeral director.	Certification:	27. Manner of Death  1 KD Natural 5 Pending (Month, Day Year)  2 Accident investigation  3 Suicide 6 Could not be		5 Residence 6 Other (Specify)  Describe how injury occurred							
Divi	oitel or Att urs after d orel Direct lled in by i			City or Town	, State)	or Rural Route Number,						
	the Hoss hin 24 hoi the Fune npletely fi	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place, a companient of my knowledge, death occurred at the time, date and place at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the companient of my knowledge, death occurred at the comp	and due to the ca ad at the time, da	use(s) and manne ite and place, and	er as stated. due to the cause(s)						
•	2 \$ 2 8 ~		29b. Signature and title of certifier  29c. License number  29c. License number  29d. Augusture of certifier		Per 27							
0	,		30. Nameland address of person who completed cause of death (Item 23a) (Type, Print)  Howard J- Mosris m. 5753 (educate language)	lubia	md	21044						
*	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature	7								

			1 - For State Registrar	State of Marylan	d / Department of Certificate of		tal Hygiene	•				
	Physic /Medi	cal	1. Decedent's Name (First, Middle, Las	Fro	neberger	2 2	ate of Death Month Day Yea	05 4,4 5 AM				
	Examir Funeral Director	ier	4a. Facility Name (If not institution, give 2012 MC C S. Social Security Number 6. St. 215. 53. 0739 1	LOH STREET	t BA		4c. County of D ate of Birth Aonth, Day, Year)	eath  Birthplace (State or Foreign Country)				
		J.	Usual Residence of Decedent  10a. State  10b. County	10c. City	y, Townfor Location		-8-49 1	10d. Inside Pity Limits				
	with the M 3e or 28a-f it be notifie	Funeral Director	10e. Street and Number MC ()	1110H Ster	DATIMOR  101. Zip Code	E 21217	10g. Citizen of What	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
980	hours after death with the Maryland lurel', or Items 23e or 28a-f show al Exec'il wr', wal be notified at	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	S. 13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Specify ) ban, Mexican, Puerto Rican	(es or No- ,, etc.) 14. Race - Al Black, W Specify:	merican Indian, hitp, etc.				
21215-0036	I within 72 iene. r then "nai I're Medic	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decedent's Usual Occi (Give kind of work don life. DO NOT use retir KETA)	e during most of working	16b. Kind of Busine	SS/Industry  AIL				
Maryland		To Be	17. Father's Name (First, Middle, Last)  ALKED C. FRI  19a. Informant's Name/Relationship (7	NE BERGER		EV	t, Middle, Maiden Sumame) ELYN SMi					
	1 and 2 Health a tem 27 is	1	DARBARA FRONT L 20a. Meylod of Disposition	BERGER /WIFE	19b. Mailing Address (Street 2012 MC lace of Disposition (Name of emetery, crematory or other pl	www. St.	te jumber, City or Town, State  ACTO MO  20c. Location - City	21217				
Baltimore	pernit. Pages Depertment of Importent: If it any injury or o		1 V Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens	woo.	PLAUN CEMETE	ress of Facility VAVEH	OS BACTIMORE N. C. CREENE FOR	NERAL HYME				
	Pnysician		23a. Part1. Enter the disease, occomp shock, or heart failure. List only o	lications that caused the death ne cause on each line.	. Do not enter the mode of dy	TKK KOYYO A	SALTIMORE, MA iratory arrest,	Approximate Interval Between Onset and Death				
8760,	/Medical Examiner bhysician and strength strengt	ai Examiner	disease or condition resulting in death)  Sequentially list conditions, any backing to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				atery De	10 YRS				
O. Box 6	The law requires that the death certificate title has been signed by the attending phy bage 2 should be detached for use as the	/Me	ysician/Medic	ysician/Medic	ysician/Medicai	ysician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3 Ectopic pregnand	су	23d. Date of d Month	elivery Day Year
<u>α</u>	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the									
Vital Records,		Completed	Of Warner of the day of the				4a. Was an autopsy performed?  Yes 2V No 1 Yes					
Division of Vit		ation: To Be	25. Was case referred to medical examiner?  1  Yes	ck only o €)  AResidence 6 □Other (Spescribe how injury occurred	ecify)							
Divis	Hospitel or Attenc 24 hours after death Funerel Director: tely filled in by the i	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specily)	ne, farm, street, factory, office	28f. Lo <i>Cit</i>	cation (Street and Number or F ty or Town, State)	Rural Route Number,				
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	one)	sician: To the best of my know ner: On the basis of examination and manner stated.	on and/or investigation, in my	opinion, death occurred at th	e to the cause(s) and manner a ne time, date and place, and du	e to the cause(s)				
	Sill Sill Sill Sill Sill Sill Sill Sill		29b. Signature and title of certifier	Hum		se number	29d. Date signed (Mor	hth, Day, Year)				
	0		30. Name and address of person who co	· tonino	300	co yamer Pan	KOK. B	of Smore MO				
	Star Registra		31. Date filed (Month, Day, Year) MAY 0 2 200	32. B istrar's Signar	(re	W M						

			1 - For State Registrar	State of Man	yland / Depa <i>Cer</i>		alth and Mer		e2005	14752
	Physic /Medi			REEN				Date of Death Month D	ay Year	3. Time of Death
	Exami	ner	4a. Facility Name (If not institution, give  GOOD SAMARITAN  5. Social Security Number 6. Se	HOSPITAL	n ven la at historia.	4b. City, Town, or L.  BALTIMO  If Under 1 Year	ORE CITY		c. County of Death	. ,
	Funeral Director			M 20XF 6	n yrs. last birthday) 9 Yrs.		Hours   Min.	Date of Birth Month, Day, Yea 19/24/1		ace (State or Foreign ry) YLAND
	death with the Maryland ms 23a or 28a-f show	Director	MD BALTI		Dc. City, Town or Loc MIDDLE F		_		10	od. Inside City Limits 1 ☐ Yes 2 No
	ath with th	ral Dire	10e. Street and Number 627 KINGSTON I			10f. Zip Code 2122	20		itizen of What Count	ry?
036 036	72 hours after death w "natural", or Itams 23a edical Examinat must	by Funeral	11. Marital Status  1 Never Married 2 Married  **Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates:		_	anic Origin? (Specify Mexican, Puerto Rica Specify:	Yes or No- n, etc.)	14. Race - America Black, White, e	tc.
1215-0	within 72 hours ene. than "natural", he Medical Exe	Completed	15, Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 8TH	cation e completed) College (1-4or 5+)	(Give k	ent's Usual Occupation of work done during NOT use retired)	ing most of working	I	Kind of Business/Indu	NT OF
yland 2	2 should be filed and Mental Hygi is markad othar aumatic avant, II	To Be Co	17. Father's Name (First, Middle, Last)  EDWIN JOHN	ISON	DATCA		DER/DOME 3. Mother's Name (Fin VIRGINI	st, Middle, Maide		ERVICES
more, Mar	ss 1 and of Health itam 27 other tr		19a. Informant's Name/Relationship (Ty  DARLENE GREENE  20a. Method of Disposition  1 ☆Burial 2 □ Cremation 3 □ R  ' 4 □ Donation 5 □ Other (Specify)	/ DAUGHTI	ER 627 20b. Place of Dispos	KINGSTO	Number or Rural Ro	ute Number, City BALTIMC 20c. L	or Town, State, Zip C	MD 21220
Baltii	permit. Page Department of Important: if any injury or once.		21. Signature of Tuneral Service Licens.  23a. Pen 1 Enfer the disease, or complished, or heart failure. List only or	cations that caused the	22.	Name and Address of	of Facility HOWEL TY HEIGH	L FUNER	, BALTIN	21207 MORE, MD
	Physician /Medical Examiner		Immediate Cause (Final disease of condition resulting in death)	POSS I	BLE ensequence of):	MYOC	ARDIAL	INFA		ntérval Between Onset and Death
68760,	the Hospital or Attanding Physician: The law requires that the death certificate be executed in 24 hours after death.  The Funaria Director: After this certificate has been signed by the attending physician and applietely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
P.O. Box	the death certific by the attending p ached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ™No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3 □E	ictopic pregnancy Other (specify)			23d. Date of delivery Month Di	ay Year
rds, P	w requires that the de been signed by the s should be detached (	by	Part II. Other significant conditions con - END STAGE			lerlying cause given ii		23e. Did tobacco 1 ☐ Yes 2	use contribute to the	cause of death?
l Reco	The taw requate has been page 2 should	Completed		ABETE		FAILUR		24a. Was an autopsy performed?  ☐ Yes 2 ☑ No	prior to comp death?	y findings available pletion of cause of
Division of Vital Records,	Phyaician: Th this certificate al director, pag	To Be	25. Was case referred to medical	ospital:	2 ER/Outpatient	3 DOA Other:	i. Place of Death (Che 4 ☐ Nursing Home	ack only one)  Residence	6 ☐Other (Specify)	<b>B</b> 140
vision	Attanding Phy r death. actor: After thi by the funeral o	Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day Yea	At home, farm, stree	7 1 7	2 □ No	Describe how injure to the control of the control o	nd Number or Rural R	Route Number.
į	To tha Hospital or Attandi within 24 hours after death To tha Funaral Diractor: A completely filled in by the fr		29a. Certifier (Check only 2 Medical Examin	ician: To the best of my er: On the basis of exa	/ knowledge death o	occurred at the time.	fate and place, and di	ity or Town, State	and manage as above	
	To with	Medical	29b. Signature and title of certifier	and manner stated.	0	29c. License nu	mber	29d. Da	te signed (Month, Day	
			30. Name and address of person who cor	mpleted cause of death	(Item 23a) (Type, Pr	D588	1 Loch		12710	1 5 more
	Sta Registra	-	31. Date filed (Month, Day, Year) WAY 02 20	32. PS istrar's 5	ONDITU!	enter	14ah	caven.	olna wo	2/239

			State of Maryland / Department of Health and		•				
			1 - State Registrar Certificate of Death	Reg.	2005 11753				
			1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year 3. Time of Death				
	Physici /Medio			4 2	3 2005 10:42 M				
	Examir			ath	4c. County of Death				
			BONS SECOURS HOSPITAL BALTIMORE CO	S. 8 Date of Birth	N/A				
	Funeral Director		219-26-1490 1 M XXF 65 Yrs. Months Days Hours Mir		9. Birthplace (State or Foreign Country) MARYLAND				
	pu »		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits				
	Aaryla f shored at	ō			17⊈ Yes 2 □ No				
	r 28a-	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?				
	th with	a D	2 NORTH SMALLWOOD STREET 21223		USA				
	r dea	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - American Indian, Black, White, etc.				
36	rs afte	by F	1 Never Married 2 Married 1 Mes 2 No If Yes, Give 1 Mes 2 No Specify: 1 Yes 2 No Spec		Specify: BLACK				
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "neturel", or items 23e or 28a-f show event, the Mcdrel Examinar nust be notified at	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	168	b. Kind of Business/Industry				
215	ithin 7 ie. iam "in	Completed	(Specify only highest grade completed) (Give kind of work done during most of wo life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4or 5+)	orking					
	filed w Hygier other th			Sme (First, Middle, Mai	ELF-EMPLOYED				
Maryland		To Be			ILLIAMS				
ary	2 should I and Men is marker aumatic	ř	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or F						
	C1 (0 -= 6		VERNON GRANT / SON 551 S. BEECHFIELD	AVE, BA	LTIMORE, MD 21229				
Baltimore,	ges 1 and it of Health If item 27 or other to		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)		c. Location - City or Town, State				
Ë	Pa Int		`4 □Donation 5 □Other (Specify) KING MEMORIAL PK. 4/2		ANDALLSTOWN, MD				
Bal	permit. Departrimonts imports any inju				NERAL HOME 21207				
	2225		23a. Juni. Ept. (the 1s. 1s. st. or complications that caused the dear Do not enter the mode of dying, such as cardia st. S. or h. and fail re. List only one cause on each line.		E, BALTIMORE, MD Approximate				
	Physician,				Interval Between Onset and Death				
	/Medical		resulting in death)  a. Due to (or as a consequence of):	3 Ense					
	Examiner		Sequentially list conditions, b. MWIT ORGAN FAILU	RE					
	led sit	nine	Imme ate 2 use (Final disease) condition resulting in death)  a. END STAGE LIVER Did not be to (or as a consequence of):  Due to (or as a consequence of):  M. W. T. ORGAN FAILUM Cause. (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  C. Due to (or as a consequence of):	00-					
,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):	MAIH					
760,	ysicia ysicia	call							
89	ntifica ng ph s as th	Med	IF FEMALE:						
Вох	leath certificate b rattending physic I for use as the b	Physiclan/Med	23b. Was decedent pregnant in the past 12 months?		23d. Date of delivery  Month Day Year				
0	that the de led by the a detached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown		·				
<u>α</u>	res that is signed by be deta	by Ph		23e. Did tobac	co use contribute to the cause of death?				
rds	w requires been sign should be	ed b	CIRRHOSIS OF LIVER	1 ☐ Yes	2 No 3 Probably 4 Unknown				
Records,	law requas been 2 shoult	Completed		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of				
<u> </u>		Com		performed 1 ☐ Yes 2 🔀	12 death?				
Vital	Physician: r this certificantal director,	Be	25. Was case referred to medical examiner?	eath (Check only one)					
of	> .9 0	1; To	Inpatient 2 EH/Outpatient 3 DOA 4 Nursing	Home 5 Residence 28d. Describe how i	e 6 Other (Specify)				
ion	Attending I rr death. ector: After by the funer	atlor	1 Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No						
Division	r Atte er dea recto	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)				
Ö	itel or irs aft rei Di								
	Hosp 24 hou Fune tely fii	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the causeurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)				
	To the Hospitel or Attending Ph within 24 hours after death.  To the Funerel Director: After th completely filled in by the funeral	Med	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occard and manner stated.  29b. Signature and title of certifier  29c. License number  29c. License number  30. Name and address of person who contributed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  MAY 0 2 2005  32. Refistrar's Signature,  MAY 0 2 2005	29d.	Date signed (Month, Day, Year)				
	6.		Phired Oberson MD BHILLS	F	14-22-7mm				
	1 1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5309 A	ord com	I RD				
	4		DR. EDWARD I OBAZEE RANDALLS	TOWN M	D 21133				
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 0 2 2005						
	negisti	ral .	MAI ON COOL						

SALAMBONI

		•	For State Registrar	State of	Marylan	d / Depa	artment of H	ealth an D <i>eath</i>	d Mental Hy	giene 2	005	14755
			1. Decedent's Name (First, Midd	(e, Last)					2. Oate of D Month		Year	3. Time of Death
	Physicia /Medic		Ruth Godw	in					April			9:30pm M
	Examin		4a. Facility Name (If not institution	n, give street and num	iber)		4b. City, Town, or	Location of D	eath		nty of Death	
			Greater Balti				Towson	li Indor 24	Hre la D (D		timore	
	Funeral Director		5. Social Security Number 238-36-1658	6. Sex 1 ☐ M 2 ☒ F	7. Age (In yrs. 76	iast birthday) Yrs.	Months Oays	If Under 24 Hours	Hrs. 8. Date of B Win. (Month, D July 2	av. Year)	Cou	place (State or Foreign intry) th Carolina
			Usual Residence of Decedent		, ,			ĻL	July 2	.0, 172	JINOTE	ii carorina
	ylanc how		10a. State 10b. County		10c. Cit	y, Town or Lo						10d. Inside City Limits
	Ba-f s	cto	MD			Balti	nore			19.		1 X Yes 2 □ No
	ith th	Dire	10e. Street and Number	_			10f. Zip Code			10g. Citizen	of What Cou	intry?
	death with the Maryland ms 23a or 28a-f show rrivet te notified at	Funeral Director	1307 Dalton Ro			S 45	212:		0 (0		ISA	inn the state of t
	ter de Item	ı,	11. Marital Status 1 ☐ Never Married 2 ☐ Mai	12. Was Dece Armed For ried 1 ☐ Yes	ces?	.5. 13.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, P	? (Specify Yes or N Puerto Rican, etc.)	y Yes or No- an, etc.) 14. Race - American Indi Black, White, etc.		
38	ours al	þ	3 X Widowed 4 □ Divorce	If Yes Give	Э		1 ☐ Yes 2 🖾 No	Specify:		Spe	city: whi	te
70	72 ho	Completed	15. Decede	nt's Education ost grade completed)		(Give	dent's Usual Occupa	turing most of	f working	16b. Kind o	f Business/Ir	ndustry
25	within 7	du de	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use retired	)				_
22	iled w Hygier Ther ti		17. Father's Name (First, Middle	L (act)		sec	cretary	18 Mother's	Name (First, Middle	Maiden Sum	legal	L
Vin R	uld be f Aental P rrked of tic eve	To Be	William Patte	•					e Morgan	5, MB10077 0811	2	
Mary	nd 2 sho Ith and I 27 is ma readma		19a. Informant's Name/Relation Suzanne Godwin						or Rural Route Num. Ltimore, l			p Code)
more,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at ODGe.		20a. Method of Disposition  1 □ Burial 2 □ Cremation  4 ☒ Donation 5 □ Other (		1 ,	Place of Disposemetery, cre	osition (Name of matory or other plac	e)	Date	20c. Location	on - City or T	own, State
G O Baltimo	permit. Departn Imports any inju		21. Simuluran Funeral Service Ronal d	S. Wade,	if ge				ard 655 W	. Balti	more	Street
			23a. Part Enter the disease, of shock, or heart failure. Lis	r complications that cat	used the deal		altimore, ter the mode of dyin			arrest,		Approximate Interval Between
	Physician	8 6	Immediate Cause (Final disease or condition	Aso	Natur	Pino	umonia					Onset and Death
	/Medical Examiner		resulting in death)	Oue to (	or as a consec		NOT THE REAL PROPERTY.					- CALLEDON
		e e	Sequentially list conditions, b. Subversions of say, leading to minocidate to the consequence of the consequ									Meyon
	cuted nd ransit	Examiner	Sequentially list conditions, and action of the conditions cause. Enter Underlying Cause (Disease or injury that initiated events	a Clos	hidren	n Dif	sicile C	olitis			1	Ukuam
8760,	cate be executed physicien and the burial-transit		resulting in death) Last	Due to (	or as a consec	quence of):						
687	ficate physics the	edicai		d								
Вох	the Hospital or Attending Physician: The law requires that the death certific hin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending propelely filled in by the funeral director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		inth 2 ☐ Fete ant at time of c	eldeath 3	□Ectopic pregnancy □ Other (specify)				Date of deliv Month	very Day Year
P.0	that the de ed by the detached	Phy	Part II. Other significant condit	ions contributing to de	ath but not res	sulting in the u	Inderlying cause give	en in Part I.	23e. Did	tobacco use c	ontribute to	the cause of death?
ords,	w requires that been signed should be de	ted by							_ 1□	Yes 2□No	o 3∏Pro	obably 4 Unknown
Division of Vital Records, P.O.	The law a cate has by page 2 sh	Completed							24a. Wa aut per 1 🗆 Yes	s an 24 opsy formed? 22 No	b. Were auto prior to co death? 1  Yes	opsy findings available ompletion of cause of 2 No
Vite Vite	sician: Th certificate irector, pag	Be	25. Was case referred to medic examiner?	Hospital			Oth		Death (Check only			
of	Phys rthis ral dir	7	1 Yes 2 No			ER/Outpatie	nt 3 DOA	4 □ Nursi v at	ng Home 5 Res	how injury oc		ify)
o	ding th: Afte fune	thor.	1 Natural 5 ☐ Pend	ing (Mont tigation	of Injury h, Day Year)	Injury	Wor	k? Yes 2∐No		,		
Oivisi	or Atter after dea Director in by the	Certification:	3 ☐ Suicide 6 ☐ Could	minor 200. Flace	of Injury - At h ng, etc. <i>(Speci</i>	iome, farm, st fy)	reet, factory, office			(Street and Nu own, State)	mber or Rur	ral Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical Ce	29a. Certifier (Check only one)  Certify  Certify  Certify	ing Physician: To the I Examiner: On the ba	asis of examina	owledge, dea ation and/or in	th occurred at the tin	ne, date and p pinion, death	place, and due to the occurred at the time	e cause(s) and	manner as :	stated. to the cause(s)
-	To the within 2 To the comple	Mec	29b. Signature and title of certif	and mann	ioi sialeu.		29c. Licens	e number		29d. Date sig	ned (Month	, Day, Year)
	⊬ s ⊢ ō		J.C. Gu	enaual	t d	10	D006	0248		April	24, 2	2005
			J. C. Breenanalt, 1		th Charle	s Street	Print) =	3853	Balhmon	MD	212	04
	Sta Regist	ate rar	31. Date filed (Month, Day, Yea	2 2005	egistrar's Sign	ature A	ali					

			State State Registrar	of Maryland / Depa Cea	artment of Health and rtificate of Death	Mental Hygier	19/11
	² Physici		1. Decedent's Name (First, Middle, Last)  3 ARBARA	GANDEL		2. Date of Death Month	Day Year 3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give street and n NONTHOUSE TESPIT		4b. City, Town, or Location of Deat	n oin	4c. County of Death  BALT: nuln
	Funeral Director		5. Social Security Number  220-42-9799  Usual Residence of Decedent	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Ye FEB.18,19	9. Birthplace (State or Foreign Country) PA
	e-f show	ctor	10a. State 10b. County MD BALTIMORE	10c. City, Town or Lo	I MORE		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	h with the	al Director	10e. Street and Number 3411 ENGLEMEADE ROAD		10f. Zip Code 21208	10g.	Citizen of What Country?
920	vithin 72 hours after death with the Maryland liene. r then "netural", or Items 23a or 28e-1 show the Medical Examir wr must be truffied at	by Funeral	Armed F	2 X No ive	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 □ Yes 2 1 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College 1	(Give life.	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) KEEPING	rking	NTAL
Maryland	should be filed ind Mental Hygid s marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) SIDNEY		NFELD FAY	me (First, Middle, Maid	PORTNOY
	s 1 and 2 should f Health and Mer itam 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)  STEPHEN GANDEL / HUSBA	ND 3411	ENGLEMEADE ROAD	- BALTIMOR	RE, MD 21208
Baltimore,	of of it		20a. Method of Disposition  1  Burial 2 □ Cremation 3 □ Removal from  1  Other (Specify)	BETH EL M	matory or other place) EMORIAL PARK 04/2	9/2005 R	RANDALLSTOWN, State
Bal	permit. Pag Department Important: any injury o		21. Signature of Euneral Service Licensee	8		ROAD - PIK	KESVILLE, MD 21208
	rnysician /Medical		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	each line.			Approximate Interval Between Onset and Death
8760,	rate be executed by sician and the burial-transit	dical Examiner	Gause (Disease or injury that initiated events	(or as a consequence of): (or as a consequence of):	pencarace Hy,	pexic em=	
O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	nant at time of death 5	Ectopic pregnancy		23d. Date of delivery Month Day Year
rds, P.	w requires that been signed by should be deta	by	Part II. Other significant conditions contributing to ASTATUATICE BREEN C	death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?  2 14 10 3 Probably 4 Unknown
I Records,	G T	Completed	Hypotetypeidism,	Diestolia	Dysturation:	24a. Was an autopsy performed 1 Yes 2	
ion of Vital	Attending Physicien: Thr death. c death. sctor: After this certificate by the funeral director, pag	To Be	25. Was case referred to medical examiner?  1   Yes   2   No	Inpatient 2 ER/Outpatier of Injury nth, Day Year)	nt 3 DOA Other: 4 Nursing F	ath (Check only one)  lome 5  Residence  28d. Describe how in	e 6 □Other (Specify) njury occurred
Division	= = = =	Certification:	3 Suicide 6 Could not be 28e. Place	e of Injury - At home, farm, str ting, etc. <i>(Specity)</i>	eet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	To tha Hospital of within 24 hours af To the Funaral completely filled in	edical	(Check only 2 Medical Examiner: On the	ne best of my knowledge, deatl basis of examination and/or in nner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the cause urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
•	To t To t	Σ	29b. Signature and title of certifier	> hip	29c. License number 29c. 29c. License number		Date signed (Month, Day, Year)
١	2		30. Name and address of person who completed ca	use of death (Item 23a) (Type,	Print) Kenta Panda	twenty th	May you 20133
	Sta Registi	. 7 . 4	31. Date filed (Month, Day, Year) MAY 0 1 2005	Registrar's Signature			(20)

			For State Registrar	State of Maryland	d / Department  Certificate		Mental Hygier		
	Physici /Medic		1. Decedent's Name (First, Middle, Last	1 1	e		2. Date of Death	0ay Year Year O'S	3. Time of Death / 9:55p. M
	Examin		4a. Facility Name (If not institution, give	chie Hose	sice J	Town, or Location of Death  A Himo  1 Year   If Under 24 Hrs.	ro,	c. County of Death	
	Funeral Director		Usual Residence of Decedent	7. Age (In yrs) 1.	Yrs. Months	Days Hours Min.	8. Date of Birth Worth, Pay, Ya	M	aplace (State or Foreign unity)  444
	ne Marylan 8a-f ahow	Director	10a. State 10b. County	10c. City	Town or Location	re			10d. Inside City Limits 1 Yes 2 No
	eath with the ns 23a or 2	Funeral Dire	10e. Street and Number 727 Druidhi 11. Marital Status	Apt·#  12. Was Decedent Ever in U.	(60) 10f. Zip	1217		Citizen of What Cor	
5-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f ahow Jisal Exanilant: Mat be natified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	If Yes, spec	ent of Hispanic Origin? (S ify Cuban, Mexican, Puert Specify:	o Rican, etc.)	Black, White	
21215-0	within ane. than "	Completed	15. Decedent's Edu (Specify only highest grad Elementary Secondary (0-12)		16a. Decedent's Usua (Give kind of won life. DO NOT us	k done durina most of wor	king 16b.	Kind of Business/I	ndustry Schools
Maryland 2	ould be filed with Mental Hygiene. Wrked other than	To Be Co	17. Father's Name (First, Middle, Last) George Hu	inie.		18. Mother's Nan	ne (First, Middle, Maid	en Sumame)	9 33495
e, Mary	is 1 and 2 sho of Health and h item 27 is ma other trauma	(	19a. Informante Name/Relationship (7) Cheron Book	man	1222 W	(Street and Number or Ru	ral Route Number, di BUK	y or Town, State, Z	21239
Baltimore	Page nent c ant: # ary or		20a. Method of Disposition  1 Burial 2 □ Cremation 3 □ f  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens	Removal from State	lace of Disposition (Name ametery, crematory or ot	emetery	5/2/05	Location - City or 1	Town, State
Ba	permit. Departr Imports any inju		Venus M.	Suio	Varia	5 You	Pd. Ba	to.MD	Servial 2.1212
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	TRIC CARC		or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner	j.		Due to (or as a consequent).  Due to (or as a consequent)					/
<u>,</u>	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury	cDue to (or as a consequ					
09289	ate hy the	dlcal	·	d					_
.O. Box	The law requires that the death certifics tte has been signed by the attending phage 2 should be detached for use as It	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic pre			23d. Date of delik Month	very Day Year
٩	w requires that been signed b should be deta	by	Part II. Dther significant conditions co	ntributing to death but not resu	ilting in the underlying ca	use given in Part I.	23e. Did tobacc		the cause of death?
								24b. Were aut prior to co death? No 1 \(\sum \) Yes	oppsy findings available ompletion of cause of
f Vital	Physician: The I this certificate ha ral director, page	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ B	ER/Outpatient 3 DO/		th (Check only one) ome 5 Residence	6 Dother (Spec	ity) Hospice
	a t i		27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	Bc. Injury at Work?	28d. Describe how in		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune	28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work? 1 Value   2 Accident   3 Suicide   4 Homicide   4 Homicide   4 Homicide   5 Suicide   4 Suicide   4 Suicide   4 Suicide   4 Suicide   4 Suicide   5 Suicid							
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 12 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occurred a ion and/or investigation,	t the time, date and place in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier			License number	4	Date signed (Month	
,	of		30 Name and address of access up a	ministed cause of doath (Ita-		D24170	A	xi127,20	05
1	)		30. Name and address of person who con E-Tsom Riche	v Hospice 83	8 N. Eutau	1 St Baltin	Love MD 2	1201	
•	Sta Registi		31. Date filed (Month, Day, Year) / MAY 02 2	32. Resistrar's Signat	the footh	,			1

			1 - For State Registrer		aryland / Depa <i>Cei</i>	artment of tificate o			iene	5 14758	
	Physici	an	Decedent's Name (First, Middle, La.	st)	II o a			2. Date of Deat Month H-'RIL		3. Time of Death	
	/Medic Examin		Rosetta  4a. Facility Name (If not institution, give Saint Joseph	street and number)		4b. City, Town	n, or Location of Deat	1	4c. County of		
	Funeral Director		5. Social Security Number 6. S 219-16-7193 1 Usual Residence of Decedent	DM ONE	e (In yrs. last birthday) 93 Yrs.	If Under 1 Ye Months Day		8. Date of Birth (Month, Day, 4-5-	Year)	Birthplace (State or Foreign Country) Md.	
	e Maryland 8a-f show diffed at	Director	10a. State 10b. County NA		10c. City, Town or Lo Baltin					10d. Inside City Limits 1 X Yes 2 □ No	
	as or 2	i Dire	10e. Street and Number 1921 Aisquith S	treet		10f. Zip Cod 2121		1	og. Citizen of Wh. US		
9036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortent: If item 27 is marked other than "neturel", or Items 23a or 28a-f show injury or other treumatic event, it is Medical Examinational Let Lodified at injury or other treumatic.	d by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	No	Was Decedent of Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puerl No <i>Specify:</i>	pecify Yes or No- o Rican, etc.)		American Indian, White, etc. Black	
15-(	in 72 h	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Oc kind of work do DO NOT use rei	cupation ne during most of wo tired)	rking	16b. Kind of Busi	ness/Industry	
212	filed within Hygiene. Ither than "	Com	12th grade 17. Father's Name (First, Middle, Last)	College (1-4or 5		tery Co				e City Schools	
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. is marked other than eumatic event, Ite M	To Be	17. Father's Name (First, Middle, Last) Robert		Austin	·- <u>-</u>		ne (First, Middle, M tha	,	Jones	
Mar	and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship ( Gloria Hopson	Type, Print) Granddaug			eet and Number or Au iith Street				
Baltimore,	Pages 1 and nent of Health ont: If item 27 ury or other tr		20a. Method of Disposition  11 Buriat 2 Cremation 3   4 Donation 5 Other (Specification)	Removal from State	20b. Place of Dispo	sition (Name of natory or other p	place)	Date	20c. Location - Ci	ty or Town, State	
Balti	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licer	ore, Md. . North							
8760,	Physician /Medical Examiner physician and physician and the prival-transit the prival-transit pr	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b: Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 DNo 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregna Other (specify)		23d. Date of Month			
rds, P.	w requires that been signed t should be deta	ed by PI	Part II. Other significant conditions of ANEMIA	ontributing to death b	out not resulting in the un	nderlying cause	given in Part I.			ute to the cause of death?  ☐ Probably 4 ∑Unknown	
Vital Record	The ate h page	Completed by	URINARY TRACT	INFECTION				24a. Was all autops perform	y prid ned? dea	re autopsy findings available or to completion of cause of th? Yes 2 No	
of	O O	ation: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da		28c. Ir	Other	ath (Check only on ome 5 ☐ Reside 28d. Describe ho	nce 6 Other	(Specify)	
Division	el or Atters s after des el Directores din by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of inj	ury - At home, farm, str. c. (Specify)	eet, factory, office	се	28f. Location (St. City or Town	reet and Number , State)	or Rural Route Number,	
	To the Hospitel or Attending Ph within 24 hours after death.  To the Funerel Director: After thi completely filled in by the funeral	Medical (	29a. Certifier 1X Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best niner: On the basis o and manner st	of my knowledge, death f examination and/or in ated.	n occurred at the vestigation, in m	e time, date and place by opinion, death occu	, and due to the ca rred at the time, da	use(s) and mann ate and place, and	er as stated. If due to the cause(s)	
)	Tot Your	Z	29b. Signature and title of certifier  A. J. L	Lelou, N	1.8.	29c. Lice D	17695	/	A	Month, Day, Year) 16,2005	
	5		30. Name and address of person who	completed cause of d							
į			31. Date filed (Month, Day, Year) MAY 0 2 20	37 Registr	State 31. Date filed (Month, Day, Year) 37. Registrar MAY 0 2 2005 May 15 April 16 April 17 A						

			1 - For State Registrar	State of Maryl	-	artment of I		-	giene Reg. No.20	115	1,750
ĺ	Physici	100	Decedent's Name (First, Middle, Last  Elanda	L.		Harper		2. Date of De Month	ath Day	Year	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give	n.	SPITAL	· · · · · · · · · · · · · · · · · · ·	or Location of Death	1	4c. Count	ZOOS y of Death JA	0.114
	Funeral Director		5. Social Security Number 6. S 217–74–9011 1		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bir (Month, Da		9. Birthp Coun	lace (State or Foreign ltry) Md.
	Maryland f show	tor	Usual Residence of Decedent	10c.	. City, Town or Lo	cation timore				1	0d. Inside City Limits 1  Yes 2  No
	death with the Maryland me 23a or 28a-1 show rmust be notified at	al Director	10e. Street and Number 3937 Greenmount	Avenue		10f. Zip Code 212.	18		10g. Citizen of USA		itry?
320		by Funerai	11. Marital Status  1  Never Married 2  Married 3   Widowed 4   Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🕱 No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		ce - Americ ck, White,	
1215-UU36	within 72 hours after ene. then "natural", or fte	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of world)	king		b. Kind of Business/Industry	
and 2		To Be Co	12th grade 17. Father's Name (First, Middle, Last) James		Harper		18. Mother's Nam	ne (First, Middle	Maiden Sumar		ity School
Mary	and and sm	F	19a. Informant's Name/Relationship (	Гурө, Print) Sister	T.		and Number or Ruent A				Code) 21218
more,	Pages 1 and 3 nent of Health int: If Item 27 iry or other tri		20a. Method of Disposition  1  Burial 2 Cremation 3   4  Donation 5 Other (Specify	Removal from State	b. Place of Dispo cemetery, crea		ce)	Date	20c. Location	City or To	wn, State
Daltimor	permit. Pages Department of I Important: If Its any injury or o		21. Signature of Funeral Service Licer	wans		2. Name and Addre March F.I			imore, M E. Nort	id. 2	21202
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or commissions, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the done cause on each line.  a	5	ter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
,00/9	death certificate be executed e attending physicien and id for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a con  c. Due to (or as a con  d.							
O. Box og	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	Ectopic pregnanc	У			te of deliver	ry Day Year
cords, r	The law requires that the de sie has been signed by the a page 2 should be detached	by	Part II. Other significant conditions of	ontributing to death but not	resulting in the u		ven in Part I.		obacco use con		e cause of death?
T T	The larate has	Completed	SARCOIDOSI	2				24a. Was autor perfo	rmed?	Were autop prior to con death? 1  Yes	osy findings available appletion of cause of
or vital	Phy this	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Impatient 2	2 ER/Outpatier		26. Place of Dea ner: 4 ☐ Nursing Ho	ome 5 Resid			)
UNISION	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	Natural 5 Pending investigation  3 Suicide 6 Could not be determined	(Month, Day Year	r) Injury	M 1□			Street and Numb		Route Number,
2	e Hospital of 24 hours at le Funeral Distriction (1914)	Medical Ce	29a. Certifier  (Check only one)  Certifying Ph 2 Medical Exam	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at the til vestigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and madate and place,	anner as sta and due to	ated. the cause(s)
	within To the comp	Me	29b. Signature and title of certifier  Bosse	jeily, r	1.0	29c. Licens	5306		29d. Date signe 04/2	7/2	005
	Sta Registr	100	31. Date filed (Month, Day, Year)	32. Registrar's S	Item 23a) (Type,	Print) ETO					AL MDZ1Z39
	5	"	MAY 0 2 2005	DUREN JO							

DHMH 17 Rev 1/2001

ELANDA

**JET** 05-02840 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

State Unpend Item 23a&27 per me G843 5-17-05 tas

Registrar

Reg. No. 1 5 Milton Harriston 1. Decedent's Name (First, Middle, Last) 2. Date of Death Milton Hairston 3. Time of Death Dav **Physician** Month Year Milton Harriston 23 Р 2005 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 666 E. 27th St. Baltimore City
If Under 1 Year | If Under 24 Hrs. Baltimore City

9. Birthplace (State or Foreign
Country)

Md 5. Social Security Number 6. Sex 1 M 2 ☐ F Date of Birth (Month, Day, Year) 7-26-49 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 55 Director 214-56-4448 Yrs. Md. Usual Residence of Decedent the Maryland 10c. City, Town or Location Baltimore 10b. County 10a. State 10d. Inside City Limits show treumatic event, the Medical Examiner must be notified at NA Md. Director 1 XYes 2 □ No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21218 666 E. 27th Street USA or frems 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "netural", or Iter Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) Cab Driver Diamond Cab 10th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cannon Cleopatra Hairston James 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daughter Cecelia White 705 Venable Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Itel any Injury or ott 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Carmel Cem. 4-29-05 Dundalk, Md. Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 1101 E. North Ave. March F.H. East ou \_ON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to infriedrate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or). Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached the 9☐ Unknown 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ∠Yes 2 □ No autopsy performed? Yes 2□No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other:  $_{4}$  Nursing Home  $_{5}$  Residence  $_{6}$  XOther (Specify) Scene 0 1

Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. 2 Accident I Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) W) OCME Uprole April 24 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10/2 ence

State Registrar 31. Date filed (Month, Day, Year)
MAY 02 2005

MAY 02 2005

ignature

111 Penn Street

Baltimore, Maryland 21201

		State of Maryland / De 1- State Unpend Item 23a-b,27,28a-f per Registrar		_	_			
Physic		1. Decedent's Name <i>(First, Middle, Last)</i> Robert Hamblin		2. Date of Death	27, 2005 ar 3. Time of beach 3:06 P M			
/Med Exami		4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL	4b. City, Town, or Location of Death ROSEDALE		4c. County of Death BALTIMORE CO			
Funeral Director		5. Social Security Number 218 68 6008  6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Sex 1 M 2 F	Months Days Hours Min.	8. Date of Birth (Month, Day, April 2,	year) 9. Birthplace (State or Foreign Country) Tennessee			
Maryland e-f show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Maryland Baltimore E	Location		10d. Inside City Limits 1 ☐ Yes 2∕∑ No			
with the 3e or 28	i Direc	10e. Street and Number 304 Townsend Rd.	10f. Zip Code 21 221	10	og. Citizen of What Country? USA			
ife, Midifyldilla ZIZIO-000 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23e or 28e-1 show other traumatic evant, the Medical Evurta or must be notified at	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Pres 2 No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White			
Maryland < 1 < 15-0030 td 2 should be filed within 72 hours att th and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Nedical Expiri	Completed	(Specify only highest grade completed) (G.	cedent's Usual Occupation ive kind of work done during most of worki a. DO NOT use retired) motive Engineer	ng	Railroad			
aryiaria Z should be filed and Mental Hygi marked other umatic evant, I	To Be Co	17. Father's Name (First, Middle, Last) Almer Hamblin	<u>_</u>	(First, Middle, N	dle, Maiden Surname)			
e, Mar 1 and 2 sho Health and tam 27 is m			ailing Address <i>(Street and Number or Rura</i> Townsend Rd. Baltim					
DAILIMOTE,  bermit. Pages 1 an Department of Heal mportant: If Itam; any lojury or other once.		20a. Method of Disposition 20b. Place of Discemetery, Commencer, 20c. Place of Discemetery, Commencer, Commenc	sposition (Name of Crematory or other place)	Date 2	20c. Location - City or Town, State			
Defilinity (2), permit. Pages 1 an Department of Heal Important: If Itam 2 any Injury or other once.		Saltimore, Maryland  A.  Ssex, Md. 21221						
auth certificate be executed wath certificate be executed attending physicien and for use as the burial-transit	icai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. Teny, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Asphyxia  Due to (or as a consequence of):  Aspiration of for Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	reign object complic	cating a	Onset and Death			
. 0 0 0	Physician/Med		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year			
The law requires that the the law requires that the take been signed by the page 2 should be detached.	b	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		acco use contribute to the cause of death? s 2 No 3 Probably 4 Monknown			
	Completed			24a. Was ar autopsy perform 1 Yes 2	y prior to completion of cause of			
hysicl his cer	To Be	25. Was case referred to medical examiner?  1 X Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 X Accident investigation  28a. Date of Injury (Month, Day Year)  4-27-05  2:30	e of 28c. Injury at Work?	me 5 Reside 28d. Describe ho	nce 6 Other (Specify)			
E Sept of	Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)  tavern	street, factory, office		reet and Number of Rural Route Number, State) 1829 Fastern Blvd			
D 5 5 5	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o						
To the Hosy within 24 ho To the Func completely f	Me	29b. Signature and title of certifier  Jashan Malerty MD	O C M E		APRIL 28, 2005			
		30. Name and address of person who completed cause weath (Item 23a) (Ty Tasha Zavlenbern MD	111 PENN STREET,	BALTIMO	ORE, MARYLAND, 21201			
: S Regis	tate trar	31. Date filed (Month, Day, Year)  AAY 0 2 2005						

DHMH 17 Rev 1/2001

ORIGINAL

# amend item#PII, Perms 372/03/17

			State of Maryland / Department of Health and Mental H  Certificate of Death	2005 11 700
			Decedent's Name (First, Middle, Last)     2. Date of D	
	Physic /Medi			( 2/) 2005 9:05 P
1	Exami		4. On The state of Dec	ath 4c. County of Death
			Cromwell Nursing Home Baltimer	Baltimore
	Funeral Director			Dey, Year) Country)
	45		403-22-4003 80 Dec.	19, 1924 Kentucky
	nylani show		10a. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Sa-f s	ç	Maryland Baltimore Dundalk	1 ☐ Yes 2XINo
	vith th	급	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
	eath v	erai	8114 Gray Haven Road 21222 11. Maritel Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or N	United States
20	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mentel Hyglene. Important: if item 27 is marked other than "naturs!, or items 23a or 23a-f show important: if item 27 is marked other than "naturs!, or items 23a or 23a-f show important; if item 27 is marked other than all be notified at once.	by Funeral Director	11. Maritel Status	Black, White, etc.  Specify: White
21215-0020	turs!	8	3 Wildowed 4 Divorced Year or Detes: WW 1.1  15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
215	within 72 ene. than "na	Completed	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)	iss. I wild of Eddiness Madsily
21	giene.	E O	8 years Conductor-Amtrack	Railroad
Maryland	be filed tel Hygi d other event,	e B	17. Fether's Neme (First, Middle, Last)  18. Mother's Name (First, Middle)	le, Maiden Surname)
yla	Mentel	ဥ		
Mai	od 2 sho lith end 17 is ma traum	1	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Num  Janet L. Helton (Wife)  8114 Gray Haven Road Dundal	
ē	permit. Pages 1 end 2 Department of Health Important: If Item 27 I any Injury or other tra once.	- 1	Janet L. Helton (Wife)  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  Date	.k, Maryland 21222 20c. Location - City or Town, State
Baltimore,	Pages nent of int: If Ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)    Cometery, crematory or other place)	
ati	permit. Pag Department Important: I any Injury c pnce.	- 1	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility	
ä	Depa Impo any I		Duda-Ruck Funeral Home of	·
			23a. Party. Emburge disease, or complications that caused the death. Do per enter the mode of dying, such as cardiac or respiratory shock, or heaft failure. List only one cause on each line.	arrest, Approximate
1	Physician /Medical			Interval Between Onset and Death
Fort	Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Cardian properties of the condition of t	
	•	Je.	Due to (or as a consequence of):	
	outed ad rensit	Examiner	Sequentially list conditions.  Due to (or as a consequence of):	
o,	e exerian ar	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
68760,	flicate be executed g physician and as the buriel-trensit	edicai	that initiated events resulting in death) Last  Due to (or as a consequence of):	
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Вох	atten for us	cian		
P.O.	t the death certif by the attending teched for use e	Physician/M	Part II. Other eignificent conditione contributing to death but not resulting in the underlying cause given in Part I.	d tobacco use contribute to the cause of death?
	s thet ined be e dete	by P	a property of the second of th	Yes 2 No 3 Probably 4 Unknown
of Vital Records,	The law requires thet the death certi ste hes been signed by the attending page 2 should be deteched for use	8	24a. We	s an autopsy 24b. Were autopsy findings available prior to
ဝင္	e law re hes bed ge 2 sho	piet	de Levrenzo	completion of cause of death?
<u> </u>	The left he	Completed	10	Yas 2.010 1 □ Yes 2 □ No
/ita	or Attending Physician: The siter death. Director: After this certificete in by the funeral director, pag	Be	25. Was case referred to medical examiner? 26. Place of Death (Check only	one)
of	Physic this c ral dir	2		sidence 6 Other (Specify)
	After fune	Fig	27. Manneroff Death 28a. Dete of Injury 28b. Time of 28c. Injury at Work? 28d. Describe 28d. Describe 28d. Describe	r now injury occurred
Division	Attender deat	fica	2 Accident investigation 2 Accident investigation 2 Accident 3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location	(Street and Number or Rural Route Number,
á	s effer Direction	Certification:	building, efc. (Specify)  City or To	own, Stete)
	To the Hospital or Attending Physician: The is within 24 burs efter death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page			a cause(s) and manner as stated.
	the thin 2. the mplet	Medicai	one) and manner stated.  29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	5 <u>5 €</u> 5		250. Signature and the or certifier	Anal -2/ 2001
	110	-	20 Name and addish of access who completed again of death (flow 22a) (Time Print)	11/11/01,000
	10,		30. Name end address of person who completed cause of death (IJem 23a) (Type, Print)	nou 1021239
	Sta	ite	31. Date tiled (Month, Day, Year) 32. Registrar's Signature	1.
	Registi	10	MANY II 9 200E Took A Manager	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** nKa 435 PM can forc /Medical NI 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner St 9618 ton 1 Year If Under 24 Hrs. ling -170CP Social Security Number 7. Age (In yrs. last birthday) If Under 1 9. Birthplace Country) **Funeral** Months Days Hours 96-34-2889 1 M Min 2 🗆 F Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show If Item 27 is marked other then "naturet", or Items 23e or 28e-f sho: or other treumstic event, the Modical Extrainer asset be natified at 1 Yes 2 No Funeral Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9618 On 90 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No ģ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Be Maiden Sumame Pages 1 and 2 should be nent of Health and Mental ont: If Item 27 is marked o ္ဂ 19a. Informant's Name/Relationship (Type, Pri t) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 20b. Place of Disposition (Name of cametery, crematory of other place) Seabroo 20706 MI 20a. Method of Disposition Date 20c. Localion - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department Importent: t eny Injury o 5 ☐ Other (Specify) ⁴ 4 □ Donation 21. Signature Funeral Service Licenses 22. Name and Address of acility Mid 23a. Part Philar he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir fory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Immedial ause (Final disease or condition resulting in death) Onset and Death Metastatic **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to (or as a consequence of) Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and use as the burial-transit attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? Yes 2 No 1 Yes the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Inpatient 4 ☐ Nursing Home 5 ☐ Pesidence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mo 005 Greenbelt Mi

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year) MAY 0 1 2005

crn

			1 - For State Registrar	State of M			rtment of H		and M		Reg. No.	)5	147	64
	Physicia	an	Decedent's Name (First, Middle, Last,     ALEXANDER	)		ЦС	RN			2. Date of De. April	ath 23	2 <b>00</b> 5	3. Time of 6:14	Death P M
	/Medic Examin		4a. Facility Name (If not institution, give Sinai Hospital	street and number)		110	4b. City, Town, or Baltin		of Death	Аргтт		y of Death		
	Funeral Director		5. Social Security Number 6. Se 220–50–4569	7. Ag	ge (In yrs. last birth	nday) rs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bin (Month, Da OCT . 3	t, 1949	9. Birth	place (State on MD	or Foreign
	ar death with the Maryland tems 23a or 28e-f show ar must be notified at	o.	10a. State 10b. County	IMORE	10c. City, Town								10d. Inside Ci	
	r 28e-1	Director	10e. Street and Number	INUKE	DA		MORE 10f. Zip Code				10g. Citizen of	What Cou		Τ
	th with		104 PURVIS PLACE					2120	8(				USA	
36	72 hours after death with the Maryland Inetural; or items 23s or 28e-f show disal Evair Learmant ke inclified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 🕱 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba ☐ Yes 217 No	ispanic Ori in, Mexicar Specify:	gin? (Spo i, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra Bla Speci	ice - Ameri ack, White, ify:		
Maryland 21215-0036	within one.	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed) College (1-4or	5+)	(Give I	ent's Usual Occup kind of work done o OO NOT use retired	during mos	t of work	ing	16b. Kind of B		dustry	
d 2	should nd Mer marke matic	Be Co	17. Father's Name (First, Middle, Last)	+	UW	INEF		18. Mothe	er's Name	e (First, Middle,				
rylan		ToB	ROBERT  19a. Informant's Name/Relationship (T)	voe Print)		RN	g Address (Street	JUL		al Boute Numbe	er City or Tour	State 7	FORST	NER
	nd 2 s lith ar 27 is r trau		JEREMIAH HORN /		1		URVIS PL						(0000)	
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		cemetery	, crem	sition (Name of natory or other place	1		Date	20c. Location			
ıltim			* 4 ☐ Donation 5 ☐ Other (Specify)  21. Sign 1/ re a Funeral/Service Lice s	1-1/	CHEVRA	_	IAVAS CHE Name and Addres						OWN, M	D
B	permit. Departr Importa any inju		Mohay	Drug	er	89	000 REIST	<b>ERSTO</b>	WN F	ROAD - F	PIKESVI			08
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Atherosc	lorotic i	Can	diovuscu				rrest,		Approximat Interval Bet Onset and I	ween
	Examiner		Company that are divisors	Due to (or as	a consequence o	of):								
	led sit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
90,	sician and burial-transit	i Examine	resulting in death) Last Due to (or as a consequence of):											
68760,	ficate by physical transfer the control of the cont	edicai		d										
O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and oate 2 should be detached for use as the burtal-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal death		Ectopic pregnancy Other (specify)					ate of deliving	- ,	Year
0	quires that I n signed by Jid be deta	by	Part II. Other significant conditions co	ntributing to death t	but not resulting in	the un	derlying cause giv	en in Part I			obacco use con Yes 2 \( \subseteq \text{No}	ntribute to t	12	leath? Jnknown
I Records,		Completed								24a. Was autor perfo 1 \( \text{Yes} \)	an 24b osy rmed? 2 V No	Were auto prior to co death? 1 \( \sum \text{Yes}	ppsy findings mpletion of c	available ause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	- Meno		oth Oth			(Check only o				
of		tion; To	27. Manner of Death	1 ☐ Inpati 28a. Date of Inji (Month, Da	ury 28b. T		28c. Injur	4 140		me 5 Resident			(y)	
Division	deat deat ctor: / the	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	ijury - At home, far tc. (Specify)	m, stre			-	28f. Location (: City or Tox		ber or Run	al Route Num	ber,
	To the Hospitel of A within 24 hours affer To the Funerel Direction properties of the completely filled in by	edical C	29a. Certifier (Check only one)	rsician: To the best iner: On the basis of and manner s	of examination and	, death	occurred at the tin restigation, in my o	ne, date an pinion, dea	id place, ith occurr	and due to the red at the time,	cause(s) and n date and place	nanner as s , and due t	tated. the cause(s	·)
	vithin To the	Med	29b. Signature and title of certifier	and market s	14100.	<u> </u>	29c. Licens	e number			29d. Date sign	ed (Month,	Day, Year)	
	d		I highi,	miD			OCM	Ξ			April 2	24, 20	005	
1	0		30. Name and address of person who c	ompleted cause of	death (Item 23a) (	Туре, І		Penn	Str	eet Ba	ltimore	, Mar	yland	21201
*	Sta Regist	ate	31. Date filed (Month, Day, Year)	17.000	rar's Signature	1						,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 Month 4 **Physician** Year Odie Timothy Jackson, Sr. 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5414 Daywalt Avenue Baltimore NA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1XM 2□F 430-30-1776 Director 76 6-14-28 Ark Usual Residence of Decedent the Maryland Pages 1 and 2 should be filled within 72 hours after death with the Marylan nent of Health and Mental Hygiene.

and if item 27 is marked other then "naturel", or Items 23a or 28e-1 show and the the trained of the then any or other the market and Item and the trained of the trained of the trained or the trained of the trained or the trained of the trained or the trained of the tr 10a, State 10c. City, Town or Location 10d. Inside City Limits Md. 12 Yes 2 □ No Funeral Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5414 DayWalt 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Completed by Black 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Trackman Railroad 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Timothy Jackson Katherine Black ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
72956-9300 19a. Informant's Name/Relationship (Type, Print) Katherine O. Simms Daughter 1215 Pleasant Valley Place, Van Buren, Ark. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 4-29-05 Owings Mills, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave. Warren 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Prostate Cancer With Metastases Yr /Medical Due to (or as a consequence of) Examiner Diabetes Mellitus Type 11 Yr Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner and I-transit The law requires that the death certificate be executed Cerebrovasular Disease Yr Due to (or as a consequence of): attending physician a l for use as the burial-Records, P.O. Box 68760 Hypertension Yr use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9□Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Anemia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼No Osteoarthritis 24a. Was an autopsy performed? Areroxeria, Incontinence Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl. one Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: / 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funerel C 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D54749 4-27-05 30. Name and address of person who completed cause of the m (Item 23a) (Type, Print) Allen Reilly, MD. East Rolling Cross Rd. Suite 307, Balto., Md. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 0 2 2005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Gilbert 205 5 03:45am Warren Jacober Sr. Anul /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hosn-twl Glen Burnie Anne Anusel Aren del If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months\* Days 1XXM 2□ F Hours 213-26-6145 75 Yrs. MD Director Usuel Residence of Decedent 10a Stete 10b County 10c. City, Town or Location 10d. fnside City Limits 28a-f shov MD Anne Arundel 1 ☐ Yes 2 No Completed by Funeral Director Glen Burnie 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 10 North Meadow Drive 21060 "naturel", or items 23a USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Detes: 14. Race - American Indian, Btack, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Firefighter Balto. Co. Fire Dept. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) end Mentel Herbert Η. Jacober Lillian Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health e important: If Item 27 is any injury or other tree Mrs. Catherine Jacober / wife 10 North Meadow Dr., Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specific) Meadowridge Memorial 5/2/05 | Elkridge, MD 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signatu une al Service Licensee 1 Second Ave SW Glen Burnie MD 21061 MU1120 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Inmediate Cause (Final Diabetes disease or condition resulting in death) Examiner Physician/Medical Examiner usa as the buriel-transit or Attending Physician: The lew requires that the daath certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 212 No 1 🗌 Yes 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending within 24 hours efter death.

To the Funeral Director: All complately filled in by the fu 1 ∏Yes 2 ∏No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name end address of person who completed cause of death (ttem 23a) (Type, Print) Arundel Hospital MO ANCIS

Registrar

State

32 Registrer's Signature

			1 - For State Registrer	State of Mary	land / Depa <i>Cei</i>	artment of F rtificate of	leaith and M <i>Death</i>		giene () () leg. No.	15	14767
	Physici	an	1. Decedent's Name (First, Middle, Last) Thomas Michael	Jacklin			-	2. Date of Dea Month	Day	Year	3. Time of Death
dec	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Death	April	28, 2 4c. County	005 of Death	3:54 p. <sup>™</sup>
			4101 Hamilton Ave	enue			imore			N/A	
	Funeral Director		107-30-3520	7. Age (In	yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day NOV. 19	Year) 1948		lace (State or Foreign stry) ISYlvania
	iand ow		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation				1	0d. Inside City Limits
	e Many	tor	Maryland N/A		Baltimo	re					XXYes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	hat Coun	try?
	eath v	Funerai	5707 Adleigh Ave.	Apt. A-5 12. Was Decedent Ever	in 11 S 13 V	Vas Decedent of h		ncifu Vos or No.	United	Stat	
21215-0036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 ia marked other than "natural", or items 23a or 28e-f show eny injury or other traumatic evant, the Medical Exameter must be rediffed at once.	ρ	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	l l	f Yes, specify Cubi	lispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)		k, White,	etc.
5-0	natur	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced	dent's Usual Occup	nation during most of works	ing	16b. Kind of Bu		,
7	within ene. than	Jumo	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		llege Pro	•		Univer Baltim		0†
פַ	e filled at Hyg other vant,	Be C	17. Father's Name (First, Middle, Last)	<u> </u>			18. Molher's Name	First, Middle, i			
<u>yla</u>	ould b Menta	고		Jacklin				Louise			
Maryland	d 2 sh th and th and ?7 is m trsum		19a. Informant's Name/Relationship (Type Mrs. Debra L. Jack)	* .			and Number or Rura On Avenue		ore, MD		
re,	s 1 and Heal		20a. Method of Disposition	2	Ob. Place of Dispos				20c. Location -	212 City or To	
imo	Page ment c ant: if ury or		1 ☐ Burial 2 XX remation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)		Hilltop		Corp. May	2,2005	Towson	, Mai	ryland
Baltimore,	permit. Depart Import eny inj		21. Signalure of Funeral Service License	Michael E. (	Canapp 22	. Name and Addre		53	305 Har altimore	ford	Rd.
ı			23a. Part1. Enter the disease, or complications, or heart failure. List only on	e cause on each line.			ig, such as cardiac c	or respiratory arre	est,		Approximate Interval Between
	Pnysician /Medical		Immediale Cause (Final disease or condition resulting in death)	Due to (or as a co		R					Onset and Death  O MONTHS
	Examiner										
	p .;	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cuisasse of injury				.,,				
_	xecute and I-trans	Examiner	that initiated events cresulting in death) Last								
68760,	flicate be executed g physicien and as the burial-transit	caiE		Due to (or as a co							
_		<b>Aedicai</b>	IEECNALE.	White the control of							
Box	The taw requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/M	in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				23d. Date of delivery Month Day Year	
P. O.	that the	Phy	9 ☐ Unknown  Part II. Other significant conditions con		ot resulting in the un	iderlying cause giv	en in Part I	23a Did to	nacco use contri	hute to the	e cause of death?
ords,	w requires that been signed I should be det	ted by				adilying dause giv			_		ably 4 Unknown
Vital Records,		Completed						24a. Was an autops perform	y pi ned? d	rior to comeath?	sy findings available inpletion of cause of
∠it	Attending Phyalcien: Thr death. actor: Atter this certificate by the funeral director, pag	o Be	25. Was case referred to medical examiner?	ospital:	2 ER/Outpatient	Oth	26. Place of Death er: 4 \( \sum \) Nursing Hor				
ס ר	ig Physiter this neral di	$\vdash$	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time of	28c. Injun Worl		ne 5∟ Heside 28d. Describe ho			Mother-in-Law Residence
Sior	tending Ph leath. tor: After th the funeral	catic	1  Natural 5  Pending 2  Accident investigation 3  Suicide 6  Could not be	(Monan, Day 10	an, injury		Yes 2 □ No				. 100 / 40.1100
Division of	iei or Attending is after death. s after death. al Diractor: After ed in by the funer	Certification;	4 Homicide determined	28e. Place of Injury - building, etc. (S		eet, factory, office	2	28f. Location (Sti City or Town		r or Rural	Route Number,
	To the Hospitel or Al within 24 hours after or To the Funeral Dirac completely filled in by	edical	29a. Certifier 1 Certifying Physical (Check only one)	ician: To the best of more: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	occurred at the tin restigation, in my o	ne, date and place, a pinion, death occurre	and due to the ca ed at the time, da	tuse(s) and mar ate and place, a	ner as sta nd due to	ited. the cause(s)
	To t To t	ž	29b. Signature and title of codific		m	29c. License	_	29	9d. Date signed	(Month, E	Day, Year)
	27						55942		4/28	109	
1	0		PAUL FOSTER	, mn. 6	565 N	CHAR	ES ST H	-203 B	ALT. M	DZ	1204
	Sta Registr		31. Date filed (Month, Day Year) 2 20	005 32. Pogistrar's S	Signatur	and I	es st #				

	1. For State		d / Department of Health and		).
	Registrar		Certificate of Death	Reg. No. UU	14/68
Physician /Medical				2. Date of Death Month Day Ye	
Examine	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dear		
	North Arunde	1 Hospital	Glen Burni	e Anne F	Arrunde.1
Funeral	5. Social Security Number 6. Se	ex 7. Age (In yrs. la	Months Days Hours Min		Birthplace (State or Foreign Country)
Director	215-34-8897	67	Yrs.		Maryland
pus *	Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Location		
Keybe, Ernast  re, Maryland 21215-0036  s 1 and 2 should be filled within 72 hours after death with the Maryland Health and Mental Hygiene.  tiem 27 is marked other then "natural; or Hems 23e or 28e-1 show other treumstic event, the Medical Examinat must be rediffical at			Burnie		10d. Inside City Limits 1 ☐ Yes → ☐ No
or 28	10e. Street and Number	0101	10f. Zip Code	10g. Citizen of What	Country?
# # # # # # # # # # # # # # # # # # #	54 Mapledale Ave		21060	United St	tates
	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		Specify Yes or No- 14. Race - A	merican Indian, Vhite, etc.
36 Se alle alle	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2√√No Specify:		
5-003 72 hours.	3 Widowed 4 Divorced	Year or Dates:		Specify: V	
21215-003 led within 72 hours ygiene ner then "natural; it, the Medical Ens it, the Medical Ens	15. Decedent's Ed (Specify only highest grades)	de completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rking 16b. Kind of Busine	ess/Industry
75 # B # 1	Elementary/Secondary (0-12)	College (1-4or 5+)	Machinist	Manufactu	irino
d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maiden Sumame)	
/land					
Harylan Parylan 2 should be and Montal is marked or eumatic eve	19a. Informant's Name/Relationship (7	Гуре, Print)	19b. Mailing Address (Street and Number or R	Kerbe (nee Logan) ural Route Number, City or Town, Stat	te. Zin Cade)
Me and 2 salth a n 27 is	Anne R. Kerbe, wit	fe	54 Mapledale Ave Glen		-, - <i>p</i> ,
Thea Head other	20a. Method of Disposition	20b. Pla	ace of Disposition (Name of	Date 20c. Location - City	or Town, State
Baltimore, Maryland 212 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then any injury or other treumetic event, the Mental	Harial 2 ☐ Cremation 3 ☐  * 4 ☐ Donation 5 ☐ Other (Specify	nemovariiom State	metery, crematory or other place)		
mit. Fartmeartmeartmeartmearter	21. Signatur of Funeral Service Licen	ricat	lowridge Memorial May 22. Name and Address of Facility	5, 2005 Elkridge	, MD
Balti permit. Departi Importe any inju	1 2 1 5 1	augh	Kirkley-Ruddick	Funeral Home P.A.	
	23a. Part1. Enter the disease, or comp	olications that caused the death.	Do not enter the mode of dying, such as cardia	E. Glen Burnie, M	Id 21061
Dhysisian	shock, or heart failure. List only of Immediate Cause (Final	one cluse on each line.			Interval Between Onset and Death
Physician /Medical	disease or condition resulting in death)	a. Due to for as a consequ	SiS ence of:		
Examiner	Conversion the line and divine	Respir			
by, executed in and initiansit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ			
Box 68760, eath certificate be executed attending physician and for use as the burial-transit	that initiated events resulting in death) Last	c. Due to (or as a consequ	ence off:		
760, te be ev sysician de buria		240 10 (01 43 4 00113044	ones or,		
687 tificate g physi		d			
X 6 Se as	IF FEMALE:	23c. If yes, outcome of pregnar	nov.		
Bo Bath c	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal	death 3 Ectopic pregnancy	23d. Date of Month	delivery Day Year
Vision of Vital Records, P.O. Box 68 Attending Physician: The law requires that the death certificate clocath. ector: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as th	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□ Unknown	ath 5 Other (specify)		,
that that detail	Part II. Other significant conditions of	ontributing to death but not resu	Iting in the underlying cause given in Part I.	23e. Did tobacco use contribut	e to the cause of death?
ds, uires la signe de be	Diabete	& mellitus	\$	1 Yes 2 No 3	Probably 4 Nnknown
al Record  The law requir cate has been si					
Ae lav				24a. Was an 24b. Were autopsy performed?	autopsy findings available to completion of cause of
al E				1 ☐ Yes 2 No 1 ☐ Y	
Vital Rec		Hospital:	04	ath Check on one	
Physical direction	Tes Zino	1 Inpatient 2 E		lome 5 Residence 6 Other (S	Specify)
on of Vital Ruding Physician: The h. After this certificate he funeral director, page	1 Natural 5 Pending	(Month, Day Year)	28b. Time of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
isio ittend death ctor: /	2 Accident investigation 3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐ No	29f Location (Street and Mumber of	Cont Conta Nove -
Division of Vital Records, P.O. Box is after death.  el Director: After this certificate has been signed by the attending ed in by the funeral director, page 2 should be detached for use.	4 Homicide determined	building, etc. (Specify,	)	28f. Location (Street and Number of City or Town, State)	Hurai Houle Number,
Hospi 4 hou Funer tely fill	29a. Certifier Certifying Ph	ysician: To the best of my knowniner: On the basis of examinati	vledge, death occurred at the time, date and place on and/or investigation, in my opinion, death occurred.	e, and due to the cause(s) and manner arred at the time, date and place, and o	as stated.
thin 2 of the orthographical theorem orthographical the orthographical theorem orthographical the orthographical theorem orthographical theorem or	5,	and manner stated.	29c. License number	29d. Date signed (M	
To To Con	1 A-On 1	7 / 00000	man Page 17	O X - 1 2	One, Day, Teal)
6,	- riceywice (	1. Luyem	- 1,000 DOOS 1/4	x o April 3	2005
	30. Name and addreg of person who o	completed cause of death (Item	0 F 10 F 17 F 17 F	Hospital, Glen	Burnie
State Registrar	1111 U & 711115	32. Registrar's Signati	ure		

			1 - For State Registrar	State of Mary		artment of F			giene Reg. No.	2005	11.760	
	Physici		1. Decedent's Name (First, Middle, Last)  Robert L. Kable, Jr					2. Date of De Month	ath Day		3. Time of Death	_
	/Medic Examir		4a. Facility Name (If not institution, give s 7919 Elvaton Rd.			4b. City, Town, or			4c.	County of Deat		
	Funeral Director		5. Social Security Number 218-22-3632 €6. Sex	7. Age (In	yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days			th y, Year)	9. Birti Co	hplace (State or Foreign buntry) y Land	
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland Anne Aruno		c. City, Town or Lo						10d. Inside City Limits 1 □ Yes 2√√No	_
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "natural; or Items 23e or 28a-f show any injury or other treumatic event, If a Maryland Eva: if at fixal be neithed at once.	d by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Year or Dates:	1946-	10f. Zip Code  21061  Was Decedent of H If Yes, specify Cubs  1 Yes	an, Mexican, Pue	Specify Yes or No into Rican, etc.)	Unit	ted Stat 14. Race - Ame Black, White Specify: Whi	tes rican Indian, e, etc. ite	
Maryland 21215-0036	ed within 72 giene. er than "nat	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired & Dye Ma	during most of w 1)	orking		ufactur:	•	
ryland	should be file ind Mental Hy s marked oth umatic event	To Be (	17. Father's Name (First, Middle, Last)  Robert L. Kable, St  19a. Informant's Name/Relationship (Ty)	le, Maiden Surname) LY Liber, City or Town, State, Zip Code)								
Baltimore, Ma	Pages 1 and 2 s nent of Health an snt: if item 27 is ury or other treu		Dolores M. Kable /  20a. Method of Disposition  1 □ Burial / 2 2 Cremation 3 □ R  '4 □ Donalon 5 □ Other (Specify)	Wife	7919 Ob. Place of Dispo	Elvaton sition (Name of matory or other place	Rd. Gler	n Burnie, il 27,	20c. Lo	ocation - City or	Town, State	
Balt	permit. Departn importe any inju		21. Signatury Funeral Service License	ome E Burni	P.A. Le, MD 2							
	rnysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	Hatic	er the mode of dyin	g, such as cardia  Con	ac or respiratory at	o h	ip	Approximate Interval Between Caset and Death	5
8760,	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co								
O. Box 6	at the death certific by the attending p tached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy			4	23d. Date of deli Month	very Day Year	_
α_	w requires that been signed b should be deta		Part II. Other significant conditions cor	ntributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did to			the cause of death?	
Records,		Completed						24a. Was autop perfo 1  Yes		death?	topsy findings available completion of cause of	
n of Vital	Attending Physicien: The releath. ector: Atter this certificate by the funeral director, pag	on: To Be	25. Was case referred to medical examiner?  1  Yes XX No  27. Manner of Death  XXNatural 5 Pending	lospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ☐ ER/Outpatier  28b. Time of Injury	-	er: 4 Nursing	Home XX Resident Part 1 Page 1	dence (		ufy)	
Division of	Hospitel or Attending 124 hours after death. Funerel Director: After tely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	At home, farm, str	M 1 🗀	Yes 2□No	28f. Location (S City or Tox			ral Route Number,	
		edicai C	29a. Certifier X1 Certifying Physical Control (Check only one)	sicien: To the best of moner: On the basis of exa and manner stated.	y knowledge, deatl mination and/or in	occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	_
)	To the within 2 To the complete	S		m.D.		29c. License	4413		Apri	e signed (Month 1 27, 2	005	
	10		30. Name and address of person who co			er st.	Baltin	nore	mD	2122	5	
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 2 200	3 Registrar's	Signature	de						

DHMH 17 Rev 1/2001

PATRICIA

KITZMILLER,

		•	For State Registrar	State of Maryla	-	artment of I			anno	1 f fra ann
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last,  4a. Facility Name (If not institution, give	Catheril		Lindle 4b. City, Town,	1 CV or Location of Dea	May o	Day Year / 2 0 0 4c. County of Dea	35 5: 40/T M
	Funeral Director			7. Age (in y	s. last birthday) Yrs.	If Under 1 Year Months Days			1916 Mar	rthplace (State or Foreign Country) "Yland"
	Ne Maryland	Director	Usual Residence of Decedent  10a. State 10b. County  Md. Baltimon		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2☐ No
	with the		10e. Street and Number  1 Clarks Lai	ne		10f. Zip Code 213	36	10g.	Citizen of What C	•
980	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event. The Madical Examinations is confilled at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Married 4 Divorced	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:			Hispanic Origin? (S ban, Mexican, Pue	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	erican Indian,
21215-0036	d within 72 ho glene. In than "natur	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire Housewi	during most of wo	orking	. Kind of Business	
Maryland 3	should be filed and Mental Hygli marked other umatic event. II	To Be C	17. Father's Name (First, Middle, Last)  John Ross				S	me (First, Middle, Maid ylvia Turn	baugh	
	1 and 2 sho Health and Iem 27 is my		19a. Informant's Name/Relationship (Ty Patricia Blair =					ural Route Number, Ci		Zip Code)
nore,	ages 1 and of He It If Item		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ F			osition (Name of matory or other pla			. Location - City or	
Baltimore,	permit. Pages I Department of H Important: If Ite any injury or ot		21. Signatur of uner Service Licens	ge of	2 1	2. Name and Address Ckhardt	ess of Facility Funeral	y 3, 2005 . Chapel, P.	Α.	21117
8760,	death certificate be executed e attending physician and burial-transit ad for use as the burial-transit	icai Examiner	23a. Part 1. Enter the disease, or comples shock, or feart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)	equence or):	Arter	N .	C or respiratory arrest,		Approximate Interval Between Onset and Death  Y-filvs
.O. Box 6	that the death certifica led by the attending pl detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3[	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	blivery Day Year
٥	w requires that the s been signed by th should be detache	by	Part II. Other significant conditions con		esulting in the u	nderlying cause gr	ven in Part I.	23e. Did tobacc		o the cause of death?
of Vital Records,	The laste has	Completed	Chronic re Peripheral	nal tai	dure dis	ease		24a. Was an autopsy performed 1 Yes 2	prior to death?	
ion of Vit	ing Physici	atlon; To Be	25. Was case sterred to medical examiner?  1 Yes 2 No   27. Manner of Death  1 Matural 5 Pending investigation	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie	f 28c. Inju	ner: 4 Jursing	eath Check on one  Home 5 Residence 28d. Describe how in		acify)
Division	or after Dire	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	cify)			28f. Location (Street City or Town, St	tate)	
	ns Hospital n 24 hours ne Funeral stetely filled	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one)	sician: To the best of my kinner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the ti vestigation, in my	me, date and plac opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner a and place, and dur	s stated. e to the cause(s)
)	To the l	Me	29b. Signature and title of certifier	my,	MI	29c. Licens D 5 9	se number		Date signed (Moni	th, Day, Year)
	8		30, Name and address of person who co	20 Sensu	n A	Print) IMUQ	1301	timore	Maryl	and 2127
	Sta Registi	100	31. Date filed (Month, Day, Year)	32 Aegistrar's Sig	nature	and I			1	

DHMH 17 Rev 1/2001

			1 - State Registrar	State of Marylan		irtment of F		_	giene	005	11.7	70
e.			Decedent's Name (First, Middle, Last)					2. Date of De	ath	000	3. Time of D	eath
	Physicia		Eugene	Wayne	L	ullo		APril	26	2005	19:17	М
>	/Medic Examin		4a. Facility Name (If not institution, give s				or Location of Dea	ith	- 1	County of Death		
	LAGIIIII	CI	8142 Harold Court			Glen	Burnie		A	nne Aru	nde1	
	Funeral			7. Age (In yrs. M 2□F 52	last birthday)	If Under 1 Year		s. 8. Date of Bir	th Vans	9. Birthpl	ace (State or I	Coreign
	Director		180-44-2775 <sup>1</sup>	<sup>M 2□ F</sup> 52	Yrs.	Months Days	Hours Mir	8. Date of Bir (Month, Da 12-10-	1952	PA	lace (State or I try)	
	g _		Usual Residence of Decedent	10.00								
	arylar show	_	MD 10b. County Anne Ar		y, Town or Lo en Burn					1	0d. Inside City 1 ☐ Yes 2	
	Ba-f	cto										
	vith th	Director	10e. Street and Number	A = 1 A		10f. Zip Code			_	en of What Coun	try?	
	ath v		8142 Harold Court		0 1.0.1	21061		2	USA			
	er de item	Funerai	11. Marital Status  1 Never Married 2 Married	2. Was Decedent Ever in U. Armed Forces?	.5.	vas Decedent of F f Yes, specify Cub	an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 1	<ol> <li>Race - America</li> <li>Black, White, e</li> </ol>		
2	rs aft	by F	3 Widowed 4 Divorced	1反Yes 2□No Man If Yes, Give 1972 Year or Dates: 1976	- Ines	☐ Yes 2X No	Specify:		5	Specify: Wh	ite	
3	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do chter than "natural", or items 23s or 28s-( show at other than "natural", or items 23s or 28s-( show svent, the Modical Exercities mast be notified at		15. Decedent's Educ		16a. Deced	lent's Usual Occup	pation		16b. Kin	d of Business/Ind	lustry	
2	n n	Completed	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retire	during most of w	orking				
7	y with	E	Elementary/Secondary (0-12)	Coltege (1-4or 5+)		Security	Officer		Se	curity		
2	e filec I Hyg othe	a l	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle				
U	lid be lenta rked lic sv	To B	Gerald Lullo				Mar	vel Lull	0			
<u> </u>	shou and N ama uma		19a. Informant's Name/Relationship (Typ	e, Print)				Rural Route Numb				
Ĕ	alth a		Elma Lullo / Wife		81	42 Harol	d Court	Apt. 1A	G1en	Burnie,	MD 210	)61
Dalilli Ole,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Martal Hygelen. Both the state of the important: It flem 23 a or 28s-1 show any injury or other traumatic event, it a Modical Examinator must be notified at once.		20a. Method of Disposition  1 Burial Doration 3 Re  4 Donation 5 Other (Specify)	aphoval from State Che	lace of Dispo emetery, cremes sapeak Cent	sition (Name of natory or other pla e Cremat	ion May	Date 1, 2005	20c. Loc Stev	ation - City or To rensvill	wn, State e, MD	
	artm ortar injur		21. Signature of Funeral Service License	θ.		. Name and Addre	ss of Facility		1	Second .	Ave. S.	.W.
ŏ	Departimbo		· /	₩014	H Si	ngleton	Funeral	Home, P.	A. G1	len Rurn	ie MD	2106
г			23a. Parri. Enter the disease or complic shock, or heart failure. List only on	cations that caused the deat						July Durin	Approximate Interval Betwe	
	Physician		Immediate Cause (Final		2010	entic	1100	× 1)	600	16.00	Onset and De	
ő	/Medical		disease or condition resulting in death)	Due to (or as a conseq	uence of):	RUITE	11671	1:00	10071	5		
	Examiner			1- )inbe	tes	M	ellite	rt D				
	* = =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a conseq	uence of):							
	ocuted nd transi	Examiner	that initiated events									
Š	e exe		resulting in death) Last	Due to (or as a conseq	uence of):							
0070	ate b hysic the bi	lica	d									
Ö	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE:									
מ	ath ce ttend or usi	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1□Live birth 2□Feta	Ideath 3□	Ectopic pregnanc	y		23	3d. Date of deliver Month	ry Day Yea	ar
	e des	sici	1 Yes 2 No	4☐Pregnant at time of d 9☐Unknown	eath 5	Other (specify) _				WORL	Day 16	"
Ċ	The law requires that the ate has been signed by th page 2 should be detache	Phy		Asibustian to death but not and	ultina in the sur		on in Book I	an Dide	abaaaa u			4h 2
ń	res the	Ď	Part II. Other significent conditions con	mouning to death out not les	uiting in the ui	idenying cause giv	ren in Panti.		res 2	e contribute to the No 3 ☐ Proba	5-	
SD IOSS	requi	ted							165 2	1140 3 11006	oly 4	(IIOWII
n D	2 3	npie						24a. Was auto	sy		osy findings av	ailable se of
	The cate bage	Completed						1 Tes	rmed? 2 <b>ZN</b> No	death? 1 ☐ Yes	2□ No	
VIII A	Physician: The law this certificate has traidirector, page 2 s	Be	25. Was case referred to medical examiner?					eath (Check only o	ne)			
5	hysi this c	2	195 2 100		ER/Outpatien	1 3 DOA		Home 5 XResi			)	
	ing P	on:	27. Manner of Death 1   Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui		28d. Describe	now injury	occurred		
VISIO	Attending is death. ector: After by the fune	ertification:	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No		2			
<u> </u>	or At after d Direct in by	rtil	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str y)	eet, factory, office		28f. Location (		Number or Rural	Route Numbe	۲.
_	To the Hospital or Attending Physician: The within 24 burs after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	O	Don Codffor	Joins To the best of and	underder 1			1				
	the Hospital hin 24 hours of the Funeral upletely filled	edical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 Medical Examin	icien: To the best of my kno ter: On the basis of examina	wiedge, death ition and/or inv	occurred at the tile restigation, in my o	me, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) a date and p	ind manner as sta place, and due to	ated. the cause(s)	
	thin thin this mple	Med	29b. Signature and title of certifier	and manner stated.	Buile	29c. Licens	se number		29d Date	signed (Month, L	Dav. Year)	
,	or with	1	11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	27	F CC P			54			3	
	1/1		Mille	11	010	100		7		1201		
-	10		30. Name and address of person who con	mpleted cause of death (Item		95 A	7m 8:-	in the second	211	ر کا کی		
	Sta	nto-	31. Date filed (Month, Day, Year)	22. Registrar's Signa		13/1	prieri	CM	416	00		
	Registr		MAY 0 2 2005		Bess	W						

900	,		1 - For State Registrar	State of Marylar		artment of I		Mental Hy	/giene Reg. No.	005	14773
	Physic		Decedent's Name (First, Middle, Last     Paulin Loyal	")				2. Date of D Month April	eath	2005 Year	3. Time of Death 11:26 A M
	/Medi Examii		4a. Facility Name (If not institution, give 1101 East 33rd Str	,		4b. City, Town, Baltimo	or Location of Dea			County of Death	1-2000
	Funeral Director		5. Social Security Number 6. Se 213 54 3414 Usual Residence of Decedent	х ] м 2XI F 57	last birthday) Yrs.	If Under 1 Year Months Days				Cour	place (State or Foreign ntry) Ginia
	yland		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				1	10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show	ctor	Maryland		Balt	cimore					1⊠Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cour	ntry?
	eath v	eral	2549 Kirk Avenue	12. Was Decedent Ever in U	16 12 1	212		C		USA	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23s or 28s-f show any highty or other traumatic avant. The Medical Exacting Insual by notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Yes, specify Cub	Hispanic Origin? (: ean, Mexican, Pue Specify:	to Rican, etc.)		4. Race - Americ Black, White, Specify: Bla	etc.
21215-0036	thin 72 ho e. an "natura Meale:	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	(Give	lent's Usual Occu kind of work done OO NOT use retire	during most of we	orking	16b. Kind	d of Business/In-	dustry
21	led wii lygien har th it. I've		12		Parki	ng Assist				ate Scho	xol
Maryland	d be fil	o Be	17. Father's Name (First, Middle, Last)  Robert Gillispie					me (First, Middle ae Willia		Sumame)	
ary	shoul ind Me inark	To	19a. Informant's Name/Relationship (T)	vpe, Print)	19b. Mailir	g Address (Stree	and Number or F			Town, State, Zip	Code)
Ž	and 2 saith a n 27 is er tra		James Loyal (Son)				n Rd. Bal	ltimore,	Md. 2	21221	
Baltimore,	f itan fitan or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, cren	sition (Name of natory or other pla		Date		ation - City or To	
tim	it. Pag rtment rtant: njury		`4 □Donation 5 □Other (Specify)	Ho			rdens 5/			more, M	aryland
Bal	permi Deper Impor any Ir		21. Signature of Funeral Service Licens  23a Part 1. Enter the disease, or compl	rkouske	14	107 Old I	ess of Facility Ki Funera Eastern <i>1</i>	venue E	ssex.	Md. 212	221
8760,	/Medical bhysician and physician and physician and the prival-transit into prival-transit	dlcal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)	uance of).	vesclero t	ric Cardl	iovascuk	v di	sesse.	Onset and Death
P.O. Box 6	The law requires that the death certific site has been signed by the attending p hage 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	33c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3	Ectopic pregnanc Other (specify)	у		23	d. Date of delive Month	ry Day Year
	w requires that been signed t should be det	by	Part II. Other significant conditions con Diabetes melli		ulting in the ur	derlying cause gr	ven in Part I.		obacco use		e cause of death?
Il Records,		Completed							an psy ormed? 2 No	death?	osy findings available npletion of cause of 2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	fospital:		Ott		ath Check onl			at acomo
of	ding h. After fune	ition: To	1X Yes 2 No Can	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	4 🗀 Nursing r	dome 5 ☐ Resi 28d. Describe			at scene
Division	To the Hospital or Attandi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At h building, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location ( City or To		Number or Rura	l Route Number,
	To the Hospital or within 24 hours afte to the Funaral DIracompletely filled in the	edical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tile estigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) ar date and pl	nd manner as sta lace, and due to	ated. the cause(s)
)	Tot. Totl	Me	29b. Signature and title of certifier	102 De	_	29c. Licens	G.M.E.			30, 200	
	6		30. Name and address of person who co	empleted cause of death (Item	n 23a) (Type, I		Street,	Baltimo	ore. M	Marvland	21201
	Sta Registr	- 200	31. Date filed (Month, Day, Year) MAY 0 2 2005	32. Registrar's Signa	ture Soes		,			<u> </u>	

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	For State Registrar						Death		Reg. No.	05	1477
Physician	n	1. Decedent's Name (First, Middle	•						2. Date of D Month	Day	Year	3. Time of Death
/Medical	1		lewshaw						4		2005	
Examiner	•	4a. Facility Name (If not institution,	-		TAITER			or Location of Dea	th	4c. Count	of Death	
5		FRANKLIN SQUAR  5. Social Security Number	6. Sex		yrs. last birth		Under 1 Yea		8. Date of B			
Funeral Director		217-76-8547	1□M 2√X	¥ 46	•		onths Days		Aug. I	2, 1958	Mar	nplace (State or Fore untry) 'Yland
land	-	10a. State 10b. County		10	c. City, Town	or Location	on					10d. Inside City Lim
Mary I sh	<u> </u>	Maryland Balti	more		Baltim	ore						1 ☐ Yes 2 ☐ 1
with the Ma	ec	10e. Street and Number					Of. Zip Code			10g. Citizen of	What Co	untry?
h with		4317 Belmar Av	e.				2120	6		United	Stat	es
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Modical Exactivativative notified at once. To Re Commission by Eumaral Director	y runer	11. Marital Status  1 □ Never Married 2 A Marri 3 □ Widowed 4 □ Divorced	Arm ed 1 ☐ If Ye	Decedent Ever ed Forces? Yes 2 ☐ No es, Give X r or Dates:	r in U.S.		Decedent of s, specify Cu Yes XXN	Hispanic Origin? () ban, Mexican, Pue	Specify Yes or N rto Rican, etc.)		ce - Amer ck, White y: Whi	
ed within 72 hours a ygiene. In than "natural", of the Modical Exert.	ear	15. Decedent		TOT Dates.	16a	 Decedent	's Usual Occi	Ination		16b. Kind of B		
nin 72 n "na n "na	plet	(Specify only highes	grade compl	<del></del>		(Give kind life. DO l	f of work don NOT use retir	upation e during most of wo ed)	orking	100. King of E	u3111633/1	noustry
d within giene.	Ę	Elementary/Secondary (0-12)	Con	ege (1-4or 5+) 2	Cer	tifi	ed Pub	lic Accou	ıntant	Federal	Gov	ernment
be filed tal Hygi d othar evant, I		17. Father's Name (First, Middle, L	ast)					18. Mother's Na	me (First, Middle	, Maiden Sumai	ne)	
should be nd Mental markad c umatic ev	0	Thomas Gillen						Mary	Elliott			
2 should be and Mental Is marked aumatic ev		19a. Informant's Name/Relationsh	ip (Type, Prin	t)	19b.	Mailing A	ddress (Stree	et and Number or F	rural Route Numi	oer, City or Town	State, Z	ip Code)
and 2 lealth m 27 l		Robert J. Mewsh	aw / H	usband	43	17 B	elmar	Ave. Balt	imore,	MD 2120	6	
of He of He if itan		20a. Method of Disposition 1 □ Burial _ 2 ▼Cremation	3 Demoval	- 1	Ob. Place of	Dispositio		M		20c. Location		Town, State
Pages ment of I ant: If its ury or o		'4 □Donation 5 □Other (Sp		IIOIII State	Metro	Crema	atory	200	)5	Catonsvi	11e,	Maryland
permit. Departm Importa any inju		21. Signatur / Funeral Service I	icensee	<u> </u>				ress of Facility uddick Fu Hwy. S.E.				061
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications	that caused the	death. Do n	ot enter th	e mode of dy	ring, such as cardia	ic or respiratory	arrest,	ia ZI	Approximate
Physician	1	Immediate Cause (Final		ETASTA			_					Interval Between Onset and Death
/Medical	1	disease or condition resulting in death)		ue to (or as a co			-1 011				-	
xaminer	П	0										
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	ue to (or as a co	nsequence o	of):						
in and ial-transit	E	that initiated events	c									
~ @ -		resulting in death) Last	Di	ue to (or as a co	nsequence o	of):						
ing physici a as the bu	Ica		d									
attending pl	Mec	IF FEMALE:										
ath ce	an/	23b. Was decedent pregnant in the past 12 months?	10	s, outcome of pa Live birth 2	Fetal death		opic pregnan	су			ite of deliver	very Day Year
the a	Pnysician/	1 ☐ Yes 2 🕱 No 9 ☐ Unknown		Pregnant at time Unknown	of death	5 🗌 Otl	ner (specify)				21101	Day ! cal
signed by the a	5	Part II. Other significant conditio	s contribution	a to death but a	ot soculting in	the under	hina asusa a	wen is Part I	220 Did	tobo one une con	tributa ta	the cause of death?
ires ti signe d be c	6	Fait II. Other significant condition	13 CONTRIDUCTION	g to death but he	or resulting in	the under	lying cause g	IVen in Fait I.		Yes 2 No		bably 4 Unkno
w require been signature should to	Completed											
The law requires that the death ate has been signed by the atter bage 2 should be detached for the completed by Dhysician	d l								24a. Wa:	s an 24b. opsy ormed?	Were aut	opsy findings availa ompletion of cause o
cate ha									1 □ Yes	2 <b>X</b> No	1 Yes	2□ No
ysician: The continuate director, pag		25. Was case referred to medical examiner?	Hospital:						ath (Check only	one)		
hys H di		1 Yes 2 No 27. Manner of Death		1 Inpatient	2 ER/Out		DOA			idence 6 🗆 Ott		ify)
ding Ph h. After th funeral	0	1 Natural 5 Pending		Date of Injury (Month, Day Ye	28b. Ti	njury	28c. Inj		28d. Describe	how injury occur	red	
ten leat tor: the	car	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ot be	Diago of Jaiwas	At home for			]Yes 2 □No	206 Leastine	(Can - a d a l		
Dirac in by		4 Homicide determi	ned 200.	Place of Injury - building, etc. (S	Specify)	m, street,	factory, office	3		wn, State)	per or Hui	ral Route Number,
		29a. Certifier 1 X Certifying	Physician:	To the best of m	v knowledge	death oc	curred at the	time, date and plac	e and due to the	cause(s) and m	anner ac	etated
24 h 24 h etely	edical	(Check only 2 Medical in one)	xaminer: On	the basis of exa manner stated.	amination and	or invest	igation, in my	opinion, death occ	urred at the time	date and place,	and due	to the cause(s)
within 2 To the Complet	N N	29b. Signature and title of certifier					29c. Licer	nse number		29d. Date signe	d (Month	, Day, Year)
- S → Ö		1 1 Jacam	El -1.	1.11	1.1		D	61251	į	,		2005
7	ì	30. Namo and address of second	the complete	d cause of deat	/lto= 22=1 2	Tune Pri						
10	Ī	30. Name and address of person of the WASSIM EL-		grause of death	(item 23a) (i	ype, Prin	COLLAN	RE DRIVE	= RAIT	IMODE	MT	1 21327
Char				2. Registrar's	Signature	MM	34 UM	UKIVO	, ISPICI	11-101CE	TIL	4143/
State Registrar	100	31. Date filed (Month, Day, Year)	005	Biolis .	K A	2844	,					

DHMH 17 Rev 1/2001

282	25		For	State of Maryla	nd / Depa	artment of H	lealth and N	Mental Hyg	jiene	
			For State Registrar		Cer	tificate of l	Death	R	eg. No. 4 U 1)	14775
	Physici	an	1. Decedent's Name (First, Middle, Las	st)	M			2. Date of Deat _Month	th Day Yeer	3. Time of Death
	/Medic		Laverne		Murray			APRIL	22, 2005	2104 P M
	Examin	ęr	4a. Facility Name (If not institution, give				Location of Death		4c. County of Dea	ith
			UNEVERSITY HOSPIT  5. Social Security Number 6. S		s. last birthday)	BALTIMOR If Under 1 Year	E CITY  If Under 24 Hrs.	8. Date of Birth	9 Ri	rthplace (State or Foreign ountry)
П	Funeral Director			□M 2X F 47	Yrs.	Months Days	Hours Min.	(Month, Day, 5-13-	57 C	Md.
	pu ,		Usual Residence of Decedent  10a, State 10b, County	100.6	City, Town or Lo	ontion				10d. Inside City Limits
	faryla shov	ō		100.0						1 X Yes 2 □ No
	the N 28a-1	rect	Md. NA		Baltin	10f. Zip Code		1	0g. Citizen of What C	ountry?
	3a or	0 1	3112 Evergreen	Ave.		212	14		USA	
	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Was Decedent of Hi I Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Am Black, Whi	
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantinar must be notified at once.		1 Never Married 2 Married	1 ☐Yes 2X No If Yes, Give	1	1 ☐ Yes 2 ☐No	Specify:	r noari, etc.,	i i	Black
Ö	tural'	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	16a Dacer	ient's Usual Occupa	ation		16b. Kind of Business	Anductor
5	n na	Completed	(Specify only highest gra	ide completed)	(Give	kind of work done of DO NOT use retired	during most of work	ing	TOD. KING OF BUSINESS	sindustry
212	d with giene ar tha	mo:	12th grade	College (1-4or 5+)	]]	Private D	uty Nurse	e	Varies	
Maryland 21215-0036	al Hy d othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam			_
yla	ould b Ment marked	L <sub>o</sub>	Harry		Murray			uerite		rdon
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relationship	Type, Print) Sister		•			City or Town, State,	
e,	1 and Healt em 2		Maria English  20a. Method of Disposition		Place of Dispo	2 Evergre sition (Name of	1	1	20c. Location - City of	1214 r Town, State
Baltimore,	ages ent of nt: If it		1 XBurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specific			natory or other plac wne Cem.		28-05	Hillborr,	Md.
alti	mit. F partm portar / injur		21. Signature of Funeral Service Licer			. Name and Addres			timore, Md	
m	permi Depa Impo any is		> Blady	o ware		March F.H	. East		E. North A	
п			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the decone cause on each line.	ath. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. Multipl	e inje	rries				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):					
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	0						
oʻ	an an rial-tr	Еха	resulting in death) Last	Due to (or as a conse	equence of):					
8760,	icate be executed physician and s the burial-transit	dical	•	d						
Θ			IF FEMALE:	22a If you guttoome of prog	Danes.				II	
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preging the street of the street o	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
o.	that the death certiff ed by the attending detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	30	1 Other (apocny)				
<u>α</u>	The law requires that the death certifi site has been signed by the attending bage 2 should be detached for use as	by Pl	Part II. Other significant conditions of	ontributing to death but not re	esulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute t	o the cause of death?
rds	w require been sig should b							1 □ Ye	es 2∭X No 3⊟P	robably 4 DUnknown
Vital Records,	e taw re has be	Completed						24a. Was ar	n 24b. Were a	utopsy findings available completion of cause of
œ =		Con						1 Yes 2		s 2 No
Vite	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		V Oth	0.5	h (Check only on		
o	두 두 교	To	1 X es 2 No  27. Manner of Death	1 ☐ Inpatient 2 [ 28a. Date of Injury	☐ ER/Outpatien 28b. Time of		4   Iduising He		ence 6 Other (Specow injury occurred	acify)
O	iding Phi th. : After thi funeral	tlon	1 ☐ Natural 5 ☐ Pending 2 🗙 Accident investigation	(Month, Day Year)	Injury 20=10	Work M 1□	k?	0.1	struck by	a cat
Division	Atter r dea ector by the	iflca	3 Suicide 6 Could not be	e 28e. Place of Injury - At	home, farm, stre	eet, factory, office		28f. Location (St	reet and Number or R	ural Route Number,
ā	sates after al Direct	Certification:	4  Homicide determined	building, etc. (Spec	Roac	4		Baltimer	2 Mb	25+ North Ave
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edicai (	(Check only 2 X Medicel Exen	nysicien: To the best of my kr niner: On the basis of examir						
	To ths h within 24 To the F complete	Medi	one)	and manner stated.		29c. License			9d. Date signed (Mon	
	To wit		29b. Signature and title of certifier	nid		OCME			•	2005
,	5		30. Name and address of person who		em 23a) (Type			-	1.22	2003
0	2 '	1		m. D	om woar (Type,		Penn Stre	et Balt	timore. Ma:	ryland 21201
	Sta	te	31. Date filed (Month, Day, Year)	Registrar's Sign	nature				, ,	
	Registr	ar	MAY 0 2 20	05 thouse &	2. HOD	-			<u> </u>	

DHMH 17 Rev 1/2001

r			i lease	Type of Fill							_egible.	•
			1 - For Stata Registrar	State of Ma	aryland i			Health and M	ental Hy	gieņe	005	11.776
						Ce	rtificate of	Death		Reg. No.	000	19770
ŗ	• Physici	an	Decedent's Name (First, Middle, La			36 -	72-		<ol><li>Date of Dea Month</li></ol>	ath Day	_Yeer	3. Time of Death
	/Medic		Baby	Boy		MC	lock		April	20		5 1405 PM
	Examin	er	4a. Facility Name (If not institution, give	14	011	1	0 11	or Location of Death		4c. (	County of Dea	ath
	2	75		ofkins Ho	17/120	III	Bultin	nogo Cit	9		NA	
	Funeral		·	Sex 7. Age 1√2 M 2 □ F	e (In yrs. last		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day 12-11	h /, <i>Year)</i>	9. Bi	rthplace (State or Foreign
L	Director		1121	X		Yrs.	Months Days		12-11	04		NA NA
	pu .		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	our or l	a a a tia a					404 1 24 05 11 5
	anyla sho	'n	Md. NA				imore					10d. Inside City Limits 1 XYes 2 □ No
	8a-f	ctc		•		Darc						
	or 2	Dire	10e. Street and Number	<b>5</b> .3			10f. Zip Code	215		10g. Citiz	en of What C USA	Country?
	72 hours after death with the Maryland neturel', or Items 23c or 28a-f show Jisal Examirat Trius Let rollified at	<b>Funeral Director</b>	2804 Reistersto								UDA	
	tems	nne	11. Marital Status	12. Was Decedent 8 Armed Forces?		13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe van, Mexican, Puerto I	cify Yes or No- Rican, etc.)	1	<ol> <li>Race - Am Black, Whi</li> </ol>	erican Indian, ite. etc.
36	s afte		1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X N If Yes, Give	No		1 ☐ Yes 2X No	Specify:			Specity: F	Black
21215-0036	ure!	Completed by		Year or Dates:								
5	"net	lete	15. Decedent's E (Specify only highest gr		¹	6a. Dece (Give	kind of work done	pation during most of workind)	ng	16b. Kin	d of Business	s/Industry
12	within iene.	m	Elementary/Secondary (0-12) Infant	College (1-4or 5	i+)		Infant	id)			NA	
	filed Hygie ther	ပိ	17. Father's Name (First, Middle, Lasi	*)				18. Mother's Name	/First Middle	Maidan 6	Sumamol	
an(	ntal ed o ed o	Be	Ernest	W.	9	Simms	3	Celesti		Waldell S	Mollo	ck
Ë	should nd Men marke marke	To	19a. Informant's Name/Relationship					and Number or Rura	( C) 4- At t	- 0'	T- 01-1	T. O. 4.1
Maryland	C 6 8 6		Celestine Mollo					erstown Rd.		, ,		
	1 and 2 Health tem 27		20a. Method of Disposition	JK FIOLI					ate			21215
Baltimore,	Pages nent of I		1 X Burial 2 ☐ Cremation 3		ceme	etery, cre	osition (Name of matory or other pla	ice)	a10			r Town, State
Ë	permit. Page Department of Important: If any njury of		`4 □ Donation 5 □ Other (Speci		Mt		rmel Cem.	The second second second			ndalk,	Md.
39	Departiment of the control of the co		21. Signature of Funeral Service Lice	1590		2:	2. Name and Addre				e, Md.	21202
=	7 C7 7 4 01		from -/s	Leas	1		March F.				North A	Ave.
п			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each in	the death. D	o not en	ter the mode of dyi	ng, such as cardiac or	r respiratory arr	rest,		Approximate Interval Between
Ш	Physician		Immediate Cause (Final disease or condition	. Chron	10/01	200	Dispar	-3				Onset and Death 4 Months
П	/Medical		resulting in death)	Due to (or as a	a consequen	ce of	DISTUS(	_				
Ц	Examiner		Sequentially list conditions	b. Pulmo	onaru	T	insuffi	'ciencu				4 months
	7 -	Examiner	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a contraction	na of):						. ,
	cutec nd ransi	ami	that initiated events	· Extren	ne f	Prel	naturit	-U				4 months
ó	te be executed ysician and te burial-transit	EX	resulting in death) Last	Due to (or as a	a consequen	ce of):		J		-		
760,	eath certificate be executed attending physician and for use as the burial-transit	ical		_ d								
9	tifica ng ph as th	Completed by Physiclan/Med		******		-						
Вох	death certifica e attending ph id for use as th	17	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth			Textonia arasmana			23	3d. Date of de	alivery
	0 0	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at			□Ectopic pregnanc □ Other (specify) _	y ———————			Month	Day Year
Ö.	t the by th ache	hys	9 Unknown	9□ Unknown								
s, P	The law requires that the death ate has been signed by the atte bage 2 should be detached for	γP	Part II. Other significant conditions	contributing to death bu	ut not resultin	g in the u	inderlying cause gr	ven in Part I.	23e. Did to	bacco us	e contribute t	o the cause of death?
Ď	quire in sig	pa	Chronic Lung	Pisease, C	Jevelo	pin	ginto	Pulmonary	1 □ Y	es 2 🛈	rNo 3□P	robably 4 Unknown
Record	s bee	let	Insufficience	y Hur	droce	ph	alus (	holes tatio	24a. Was a	ın	24b. Were a	utopsy findings available
Re	Physician: The lav this certificate has al director, page 2	mc	Jandice	J 1 J	<i></i>	7	, 0	100010010	perfor	med?	prior to death?	completion of cause of
Vital		O	25. Was case referred to medical					26. Place of Death		2 No	1 🗆 Yes	s 20 No
5	s cert	0 8	examiner? 1 🗆 Yes2 📉 No	Hospital:	nt 2 🗆 ED/	Outnation	nt 3 DOA Oth	ner: 4 Nursing Hom				
o	Phy r this sral o	$\vdash$	27. Manner of Death	28a. Date of Injur	y 28t	b. Time o			8d. Describe ho			эспу)
on	iding Phy th. : After thi funeral	tlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	Wo	rk? Yes 2 ⊟No				
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not b		ury - At home,	, farm, sti	reet, factory, office	2	8f. Location (Si	treet and	Number or R	ural Route Number,
á	l or A after Direct	erti	4 Homicide	building, etc	c. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town			
	spite ours ours illec		29a. Certifier Certifying Pl	nysician: To the best of	of my knowled	dge, deat	h occurred at the til	me date and place, a	nd due to the c	ause/s) a	ind manner a	s stated
	the Hospitel or Attending Physician: thin 24 hours after death. I the Funerel Director: After this certifics mpletely filled in by the funeral director, I	edical	(Check only 2 Medical Exer	miner: On the basis of and manner star	examination	and/or in	vestigation, in my o	ppinion, death occurre	d at the time, d	ate and p	place, and due	e to the cause(s)
	To the Hospitel or Attenwihin 24 hours after death (To the Funerel Director: Completely filled in by the	Me	29b. Signature and title of certifier				29c. Licens	se number	2	9d. Date	signed (Mont	th, Day, Year)
•	1		Danna A	100 6	000	nn	DEC	5-000		1	- 1 3	0 2000
	1		30. Name and address of person who	completed cause of di	eath (transport	110	Print)	-000		HPI	11/2	0, 2005
	1		Deanna Mae	Tran	/0/10/11 23	м, (туре, Д.)	1110/6	St. Bo	1-tim-	3.00	MA	71787
	Sta	te	31. Date filed (Month, Day, Year)	a 32. Registra	y's Signatu e	-	WUITE	21. 12	MITTIC	VE	1.1	-1-01
	Registr		MAY 0 2 2005	Elever L	y Ap							
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		1 - For Stata Registrar	State of Maryland			ealth and I		ene g. Ng. 0 0 5	1477
Physici /Medic		1. Decedent's Name (First, Middle, Las SIDNEY MARK					2. Date of Death Month	Day Year 25 200!	
Examin		4a. Facility Name (If not institution, give Potomac Valley	Nursing Center		Rockvi1			4c. County of Dea	nery
Funeral Director		5. Social Security Number  064-26-0853  Usual Residence of Decedent	7. Age (In yrs. last)		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 22	9. Bi	rthplace (State or Forei ountry) Unk
ne Marylan 8a-f show	ector	MD 10b. County Montgome	ery Ro	ckvil					10d. Inside City Limi 1 ☐ Yes 2 ☑ N
th with the 23s or 2	al Dire	1235 Potomac Val	ley Road		10f. Zip Code	20850	10	g. Citizen of What C USA	ountry?
within 72 hours after death with the Maryland ene. than "natural", or itams 23s or 28s-f show re M. dical Exs.nit.or nast be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates:		s Decedent of Hi es, specify Cuba Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
l within 72 ho iene. r than "natui ir e Modical	ompleted	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) Unk U	cation 16 completed) College (1-4or 5+)	Sa. Deceder (Give kin life. DO	nt's Usual Occupa nd of work done d NOT use retired,	ution uring most of work	unk 1	6b. Kind of Business	/Industry un
S should be filed within and Mental Hygisne. Is marked other than aumatic event, It a M.	To Be C	17. Father's Name (First, Middle, Last)			unk	18. Mother's Nam	e (First, Middle, Ma	aiden Sumame)	u
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 shoy any injury or other traumatic event, it a Medical Examirer must be netified at once.		19a. Informant's Name/Relationship (T)  Potomac Valley Nt  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ F  1 □ Donation 5 ☒ Other (Specify)	arsing Center  20b. Place ceme. in state	1235 of Dispositi		Valley	Road Rock	City or Town, State, CVIILE, MD Dc. Location - City or	20850
permit. Departitimporti		21. St. nature of Euneral Service Licens	Nade Arest	Sta Bal	ame and Address te Anato timore,	s of Facility my Board MD 2120	655 W. I	Baltimore	Street
The law requires that the death certificate be executed  We want to be a signed by the attending physician and and a second be detached for use as the burial-transit and a second be detached for use as the burial-transit	dical Examiner	23a. Parkt. Enter the disease, or compliance, or heart failure. List only of Immediate Gause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CARDIO PULMO Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	NARY e of): & e of):			or respiratory arres	t,	Approximate Interval Between Onset and Death
it the death certific by the attending p tached for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal deat  4 Pregnant at time of death		topic pregnancy ther (specify)			23d. Date of del Month	ivery Day Year
uires that signed b id be deta	by	Part II. Other significant conditions con CHRONIC ATRIA	ntributing to death but not resulting		rlying cause give	n in Part I.			the cause of death?
	e Completed	DEPRESSION  25. Was case referred to medical					24a. Was an autopsy performe	24b. Were au prior to death?	topsy findings availate completion of cause of
ng Phys ter this neral dir	ertification: To B	examiner? 1	fospital: 1 Inpatient 2 ER/C  28a. Date of Injury (Month, Day Year)  28b.	Time of Injury	3 DOA Other  28c. Injury	ursing Ho	me 5 Residence 28d. Describe how	ce 6 Other (Specification of the control of the con	cify)
	OL	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)				City or Town, S	,	
To the Mospital or within 24 hours afte To the Funeral Discompletely filled in	edical	one)	sician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death oc ind/or invest	curred at the time igation, in my opi	n, date and place, nion, death occurr	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To the To the Complet	Σ	29b. Signature and title of certifier			29c. License			Date signed (Month $4/25/05$	
		30. Name and add ass of person who co	impleted cause of death (Item 23a)	(Type, Prin	ot)				

	1 - Stete Registrer  1. Decedent's Name (First, Midd	le, Last)	- 00	ertificat	COL	Jean	2. Date of D			3. Time of Death
Physician /Medical		lillbrook		·			Month 1	IL B	74, 2¥3	
Examiner	4a. Facility Name (If not institution Saint Jose	n, give street and number) on Medical	Center	4b. City,	Town, or	Location of Deal		40	c. County of D	eath 1timore
Funeral Director	5. Social Security Number  216-58-5161  Usual Residence of Decedent	6. Sex 7. Ag 1 ☐ M 2 💢 F	e (In yrs. last birthday 53 Yrs.	y) If Under Months	1 Year Days	If Under 24 Hrs Hours Min		irth Day, Year 23, 1	952 M	Birthplace (State or Fore Country) Aryland
show	10a. State 10b. County		10c. City, Town or I							10d. Inside City Limi
recto	Maryland Balti	more		Balt 10f. Zip		e		100 C	itizen of What	1 Tyes 21/21
ai Di	13 Danben Co	urt		10.1.2		236		.09.0	U.S.A	•
event, the Medical Evarrance must be notified at Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Mai 3 ☐ Widowed 4 🂢 Divorce	If Voc Civo		If Yes, special Yes	cify Cuba	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or Noto Rican, etc.)	lo-	14. Race - A Black, W Specify: (	
Completed		nt's Education est grade completed)	(Giv	edent's Usua e kind of wo	rk done a	uring most of wo	rking	16b. F	Cind of Busine	ss/industry
omp	Elementary/Secondary (0-12)	College (1-4or 5	5+) life.	DO NOT U. Engi		,		Com	munica	tions
BeC	17. Father's Name (First, Middle					18. Mother's Na		e, Maider	n Sumame)	000110
2	David Muel					Elizat	_	Hech		
	19a. Informant's Name/Relation Mr. Eric Mill					nd Number or Al alley CX				a, <i>Zip Cod</i> e) 204
once. To Be Comp	20a. Method of Disposition 1 □ Burial 2 【Cremation		20b. Place of Disp cemetery, cri	position (Nan	ne of		Date	-		or Town, State
	'4 □Donation 5 □ Other (		Bayview							, Maryland
once.	21. Signature of Funeral Service	Licensee		22. Name an	d Addres	s of Facility Sc	himunek	Fun	eral H	omes
	23a. Part1. Enter the disease, o	r complications that caused	I the death. Do not e						V ZIZJ	Approximate
an	Immediate Cause (Final disease or condition	only one cause on each li	 IC CARCII	NOMA	WITH	H METAS	TASES			Interval Between Onset and Death 9 WEEKS
al er	resulting in death)	a	a consequence of):							
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DHMH 17 Rev 1/2001

amend item/II, 19b, perFH, 6943, 5/2/05 Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26, 2005 **Physician** APRIL MEREN Рм 2:00 AMELIA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE JEWISH CONVALESCENT CENTER BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Year) FEB. 16, 1911 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🕡 F 94 212-05-9257 Director RUSSIA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or Iteme 23a or 286-1 show other treumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2143-B WOODBOX LANE 21209 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ☐Yes 2 🕅 No f Yes, Give 1 Never Married 2 Namied Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Be Completed by Specify WHITE 3 Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be **JOSEPH** SHARGEL ဂ္ YETTA FISHMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2143-B WOODBAX LANE - BALTIMORE, MD 21209 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an item 27 LANE - BALTIMORE, MD 21209 ALLEN MEREN / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Importent: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) CHIZUK AMUNO ARLINGTON 04/28/2005 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Nelm /Medical Due to (or as a consequence of Examiner dio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the burial-transit The law requires that the death certificate be executed that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23b. Was decedent pregnant in the past 12 mophs? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Year Month Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9□ Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? Completed by should be 1 🗌 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 - No ٩ 1 Tyes 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred : After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) To the Hospitel o within 24 hours aft To the Funeral Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 H 31617 (0 150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raltinion WD. And van 120 32. Pi gistrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

				1 - State of Maryland / Department of Health an Certificate of Death	nd Mental Hy	ygiene Reg. No.	05 14780
		Physic /Medi	cal	1. Decedent's Name (First, Middle, Last)  Ruth E. Phoebus	2. Date of D Month April	27 20	
		Examir	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of [	Death	4c. County	
		Funeral		Gilchrist Center Towson  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24	Hrs. 8. Date of B	irth	imore  9. Birthplace (State or Foreign
		Director		218-38-4511 1 M 2 KF 87 Yrs. Months Days Hours Usual Residence of Decedent	June 2	5°, Yeff917	Mary Tand
		show	5	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
		with the Marylar a or 28a-f show be notified at	Irecto	Maryland Anne Arundel Glen Burnie  10e. Street and Number 10f. Zip Code		10g. Citizen of V	1 ☐ Yes 💥 No What Country?
2		s 23a c	ralD	102 N. CHarter Rd. Apt. D 21061		United	
5 pm	920	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland tof Health and Mental Hygiene. If Itam 27 is marked other than "natural", or Itams 23a or 28e-f show or other traumatic event, the Modical Evandrer musite codified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  1 □ Ves 2 ☒ No   Yes, Give Year or Dates:	n? (Specify Yes or N Puerto Rican, etc.)	Specify	e - American Indian, kk, White, etc. White
011	1215-0036	within 72 hours ene. than "natural", the Medical Eve	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  Homemaker	f working		siness/Industry
	121	filed w Hygier thar ti			Name (First, Middle		Own Home
5	Maryland	2 should be filed and Mental Hygi is markad othar aumatic evant, i	To Be	Charles Albert Randle, Sr. Ann	na Somers		-,
1	Mar	th and the strain traum		19a. Informant's Name/Relationship (Type, Print)  Mr. T. Gregory Phoebus/Son  2802 Todkill Trace			State, Zip Code) L040
1	re,	s 1 ar		20a. Method of Disposition 20b. Place of Disposition (Name of	ay Date		City or Town, State
1/2	Baltimore,	Pages ment of ant: If It ury or o		12 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Meadowridge Mem. Pk.	2005	Elkridge	e, Maryland
10	Balt	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 ti any Injury or othar tra <u>once</u> .		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Kirkley-Ruddick  22. Train Hwy. S.	Eungral H	ome.P.A.	21061
		Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	rdiac or respiratory		Approximate Interval Between Onset and Death W-CE/CS
1/CED	3760, 🖉	ate be executed hysicien and the burial-transit	lical Examiner	d			
EXP	.O. Box 68	The law requires that the death certiticate I te has been signed by the attending physionage 2 should be detached for use as the I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Dat Mor	e of delivery hth Day Year
4	<u>s</u> , Р	res tha igned be det					ibute to the cause of death?
366	Sorc	w require been sig should b	eted	respiratory the live secondary 10	_	~	3 Probably 4 Unknown
10 64	Vital Record		Completed by		-// auto	opsy pormed? d	Vere autopsy findings available rior to completion of cause of eath?  Yes 2 No
CH	-	Physiclan: r this certific ral director,	To Be	examiner?	Death (Check only ng Home 5 ☐ Res		12 11 2 15 1
H	on of	After After fune		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 2 Pending (Month, Day Year) 3 DOX 4 Norsing 4 Norsing 4 Norsing 4 Norsing 5 DOX 4 Norsing 6 Norsing 7 Norsing 7 Norsing 8 Norsing 8 Norsing 9 Norsing 1 Norsing 9 Norsing 1 Norsing 1 Norsing 1 Norsing 9 Norsing 1 N	28d. Describe	how injury occurre	er (Specify) (135) (CO
77	Division	To the Hospital or Attanding within 24 hours etter death.  To the Funeral Director: After completely tilled in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location	(Street and Number own, State)	or or Rural Route Number,
A		e Hospite 24 hours e Funeral letely tilled	Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and properties of examination and/or investigation, in my opinion, death of and manner stated.	place, and due to the occurred at the time	cause(s) and mai date and place, a	nner as stated. nd due to the cause(s)
		To th within To th compl	Me			_	(Month, Day, Year)
	}	1		Mothery Wile, up D2500		April	28,2005
		5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  W. A. R. (e.g. G. G. Color M. Charle, J.	t ba	Cto. auc	121205
		Sta Regist		31. Date filed (MM/A Vay (Year)) 2005 Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Month Year **Physician** 11:00 AM APRIL 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** GOOD SAMARITAN HOSPIT AL BALTIMONE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 64onth Day. 7. Age (In vrs. last birthday)
Yrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Months -01-9246 10XM 20 F Director ITAINIA Usual Residence of Deceden the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County itam 27 ia marked other than "natural", or Items 23a or 28a-f show other traumatic event, I'm Medical Event et must be notified at 1 Yes 2 □ No Director TIMOR and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Year or Dates: Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) mas 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Place Wittoz 50 permit. Pages 1 and 2 states to Department of Health ar Important: If itam 27 ia any Injury or othar trauonce. ma 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. node of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician SHOCK SEPTI( disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DECUGITU Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner attending physician and for use as the burial-transit RINARY TILACT resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 PACHAN IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown CEREBIN VOISCULAR ACCI DENT 24b. Were autopsy findings available prior to completion of cause of death? DEMENTIA 24a. Was an autopsy performe OF CAILSS A 2 No HISTORY 1 ☐ Yes 2. No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 1. Inpatient Certification: To 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Injury 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ADTIL 27. 2005 zalim 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH KAVEN BOOLEVARY GOVA SAMARITAN HOSPITAL BALTIMORE - MB - 21238 Salim BAGHLi

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Regiarar's Signature

		For State Registrar	State of Ma	aryland	•		of Hea		nd Me		giene Rag. No. 9	nne	11 700
Physic	cian	Decedent's Name (First, Middle,  Lucy	Last)			Dry	yor		2	Date of Dea Month	th Day	Yeer	3. Time of Death)
/Med Exam		4a. Facility Name (If not institution,	-				own, or Loc			april	26 4c. Co	2005 unty of Death	1233 P M
		Union Memoria  5. Social Security Number		e (In yrs. la.s.	t hirthday)	If Under	Balt:	imore		Date of Birt	h	NA 9 Birth	place (State or Foreign
Funera Directo		213-26-5096	- 44	88	Yrs.	Months			Min.	II-2	16 Year)	Cou	Va.
/land		Usual Residence of Decedent  10a. State 10b. County		10c. City, 1	Town or Lo	cation							10d. Inside City Limits
e Man Ba-f sh	Funeral Director	Md.	NA		Bal	timore							1 XYes 2 No
with the or 2	Dire	10e. Street and Number	Charab			10f. Zip	21205					of What Cou	ntry?
death ms 23	eral	2101 E. Madisor	12. Was Decedent	Ever in U.S.	13. V			anic Origi	n? (Specif	y Yes or No-		SA Race - Ameri	
s after o	by Fur	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	If Yes, Give	No		iYes, speci I□Yes 2,		Mexican, Specify:	Puerto Rio	an, etc.)		Black, White, ecity:	etc. lack
thours	ted b	15. Decedent's	Year or Dates: Education		16a. Deced	lent's Usual	Occupation	n .	, , , ,		16b. Kind	of Business/In	
ithin 7:	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5	i+)			k done durir e retired)	ng most o	of working		0	**	
illed w Hygier ther th	Co	9th grade 17. Father's Name (First, Middle, L	ast)		HOME	maker	18.	. Mother's	s Name (F	First, Middle,	Own Maiden Sui		
DEMITTIOTE, IMMETYTATION AT LATE 19-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neture!, or Items 23e or 28a-f show any injury or other treumatic event, it a Modical Examinar must be mailfied at mone.	To Be	David		ringto					Gr	ace	Le	е	Brown
Mar d 2 sho lth and 27 is my troum		19a. Informant's Name/Relationshi  Jerry Pryor	ip (Турв, Print) Son			-					-	e, Md.	·
of Hea		20a. Method of Disposition  **Disposition**  **Disposition**  **Comparison**  **Disposition**   □Removal from State	20b. Plac	ce of Dispos netery, crem	sition (Nam natory or oti	e of her place)		Date	9	20c. Locati	ion - City or To	own, State	
DEMILITION Dermit. Pages Department of. mportent: If it any injury or o		`4 Donation 5 ☐ Other (Sp	ecify)	Gard	den o				5-3-0			imore,	Md.
Department of the sany in the		21. Signature of Funeral Service L	e Wan	کن			F.H.		t	Balti 1101 E	more, Nor	Md. th Ave	21202
		23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that caused nly one cause on each lin	the death. ne.	Do not ente	er the mode	of dying, s	uch as ca	ardiac or r	espiratory ar	rest,		Approximate Interval Between Onset and Death
Pnysiciar /Medica		Immediate Cause (Final disease or condition resulting in death)	a. Pheviv	-	non of:								5 days
Examine	_	On a secretarily that are distance	b.	a consequer	nce or).								
pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dispace or injury) that initiated events	Due to (or as	a consequer	nce of):								
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death certificate be executed e attending physician and of or use as the burial-transit	icai		d										
ox o o certific anding p use as	/Me	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome								23d.	Date of delive	ery
us, F.O. box od ires that the death certifica signed by the attending ph d be detached for use as the	Physician/Med	in the past 12 months? 1 □ Yes 2 X No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pre Other (spe						Month	Day Year
that the ed by the detache		9 ☐ Unknown ►  Part II. Other significant condition	s contributing to death b	ut not resulti	ing in the ur	ndertying ca	use given ir	n Part I.		23e. Did to	bacco use	contribute to t	he cause of death?
w requires been sign should be	ed by								_	1 🗆 Y	'es 2□N	o 3 Prot	oably 4 Onknown
10 8 8	Completed									24a. Was autop	sy	4b. Were auto prior to co death?	opsy findings available impletion of cause of
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Of Vita Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 2 No	Hospital:	nt 2□EF	VOutpatien	t 3□ DO	Othor					Other (Specif	(5)
on or vital ding Physicien: h. After this certific funeral director,		27. Manner of Death 1 △ Natural 5 □ Pending		ry Yea <i>r)</i> 28	8b. Time of Injury	2E M	Bc. Injury at Work?	2 □ N		d. Describe h	ow injury o	curred	
INISION Or Attending after death. Director: Afte	Certification:	2 Accident investigation inves	ot be 28e. Place of Inj	ury - At home	e, farm, stre					Location (S City or Tow		umber or Rura	al Route Number,
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0		30. Name and address of person v	the completed cause of d	eath (Item 2	(Type,	Print)	rkwa	'W 1	Baltit	NOUP N	10 3	2620	
S Regis	State	31. Date filed (Month, Day, Year)  MAY 0.2 201		ar's Signatur	beck	9		7	187 (1.1				
riegis	ou al	MAY 0-2 200	IJ WHILL	N /									

			For State Registrar	State of Ma	aryland		artmen rtificat			and M		giene	3000	)	14783
	nysicia Medic		1. Decedent's Name (First, Middle, L Susie Patrick								2. Date of De Month Apri	Day 1 23	,2005	r	3. Time of Death  11:40 am
	xamin		4a. Facility Name (If not institution, ga						Location of	of Death			County of De		
C	neral		Prince Georges  5. Social Security Number 6.		(In yrs. las	st birthday)	If Under	verl 1 Year	If Under	24 Hrs.	8. Date of Birl	h .	rince 9.B	lirtholac	e (State or Foreign
	ector		578-40-2936	1□M 2 <b>X</b> )F	85	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da March	28,1	920 C	1ov e	er,VA
land	18		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation							10d.	Inside City Limits
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or 28	ou av	Directo	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of What	Country	?
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after d	niner.	Fun	1 Never Married 2 Married	Armed Forces?			If Yes, spe		n, Mexican Specify:	, Puerto	ecify Yes or No Rican, etc.)		Black, Wi	hite, etc	
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Maryland d 2 should be file th and Mental Hy 7 is marked oth	matic	ဥ	Clem Thomas  19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	na Address	(Street a			a Royst		r Town, State	. Zip Co	nde)
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of Hea	r oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	Removal from State	20b. Pla	ce of Dispo	sition (Nar	ne of			Date		cation - City		
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scuted	the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Pulmon			stion								
<b>5 / 5U,</b> ate be executed bysician and	burial	licai Ex	resuming in death) cast	Due to (or as a	a conseque	ince of):									
OX DB/ Certificate	as the			_ d											
BOX ath cert	r use	hysician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic p	regnancy				2	23d. Date of d	,	
be death	of bed	/sici	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	4□Pregnant at 9□Unknown			Other (sp	ecify)				10	Month	Da	y Year
that the	should be detached for use as t	0	Part II. Other significant conditions	contributing to death bu	ut not result	ing in the u	nderlying o	ause give	n in Part I.		23e. Did to	obacco u	se contribute	lo the c	cause of death?
COTOS, w requires t	nid be	ed by									101	/es 2[	□No 3□	Probabi	y 4 □Unknown
ecc law re	2 (1)	ompieted									24a. Was	sy	prior to	o compl	findings available letion of cause of
VITAL HECK	. page	O									perfo 1 ☐ Yes	rmed? 2.0 No	death'		□ No
94 //	director, page	o Be	25. Was case referred to medical examiner?  1 Tes 2 No	Hospital: 1 Anpatie	nt 2∏ Fi	R/Outpatier	nt 3 🗆 DC	Othe			n <i>(Check only o</i> me 5 ☐ Resid		S □Other (Sr	necifi()	
T OT 19 Phys	<u> </u>	n: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	y 2	8b. Time o		28c. Injury Work		and the same of th	28d. Describe			ocity)	
VISION Attending ar death.	the fu	catic	2 Accident investigate 3 Suicide 6 Could not	on be			М	101	/es 2 □ !	_	201 1				
or Att	d in by	ertification;	4 Homicide determine			ie, farm, str	eet, factor	y, office			28f. Location (5 City or Tox			Hural H	oute Number,
UIVISION C To the Hospitel or Attending P within 24 hours after death. To the Euperel Director: Attent	letely fille	dical C	29a. Certifier (Check only one)  1 **XCertifying F** 2 **Medicat Exit	Physician: To the best caminer: On the basis of and manner sta	examinatio	iedge, deat on and/or in	h occurred vestigation	at the tim	e, date an	d place, a	and due to the	cause(s) date and	and manner place, and d	as state	d- e cause(s)
To the within 2	dwoo	Me	29b. Signature and title of certifier	1 /20	- A.	Λ	290	c. License	number			29d. Dat	e signed (Mo	nth, Day	y, Year)
			Migranetta	L. Slaw	2, In	, د،،		D	22435	5		Apr	il 27,	2005	5
			30. Name and address of person wh					lnrin	o MD	2000	1/4				
	Sta egistr		31. Date filed (Month, Day, Year)	32 degistra	ar's Signatu	70	sark)	Artii	<u>للاتا و ي .</u>	2030	/.T				

		•	State of Maryland / Dep.  1 - State Registrar Ce	artment of Health and Me rtificate of Death		ene 005	14784
			Decedent's Name (First, Middle, Last)	- 2	2. Date of Death	Day oo Year	3. Time of Death
	Physicia /Medic		Mary Lou Patrick		Manth April	29,2005 <sup>ear</sup>	9;А.М. м
>	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Carroll Hospital Center	Westminster  If Under 1 Year   If Under 24 Hrs.   8	B. Date of Birth	Carro	
	Funeral Director		5. Social Security Number  6. Sex 1 M 2 F  7. Age (In yrs. last birthday, Yrs.	Months Days Hours Min.	Feb.3,19		place (State or Foreign ntry) MN
			476-12-1172 80		rep.J.		
	how		10a, State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits 1 ☐ Yes 2X No
	Be-f s	cto		erstown	T 42		
	with the	Dire	10e. Street and Number	10f. Zip Code 21136	109	g. Citizen of What Cou	ntry?
	ss 234	erai	324 Lauren Hill Court  11. Marital Status 12. Was Decedent Ever in U.S. 13.		ifv Yes or No-	USA 14. Race - Ameri	can Indian,
·0	r Item	Funeral Director	1 ☐ Never Married 25 Married 1 ☐ Yes 2 1 No	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2 No Specify:	ican, etc.)	Black, White,	
21215-0036	within 72 hours after death with the Maryland ene. then "returel", or llems 23e or 28e-f show the Madical Exama account the notified at	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify:	White
5-0	72 h "netu	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	g 16	6b. Kind of Business/fr	ndustry
12	withir ane. then	duic	Elementary/Secondary (0-12) College (1-4or 5+) 12 Grade	Housewife		Own H	nme
d 2	filed Hygir other ent,	O O	17. Father's Name (First, Middle, Last)	18. Mother's Name (	(First, Middle, Ma		o in c
Maryland	lid be lental rked c	To Be	John H. Stoffels		Ann M.	Conlin	
ary	and N			ng Address (Street and Number or Rural			
Σ	and 2 ealth n 27 i			Lauren Hill Court	_	rstown, Md	
ore	ges 1 t of H If iter or oth		1 Burial 2 X Cremation 3 Hemoval from State	matory or other place)		c. Location - City or T	
Baltimore,	t. Partmen			Cremation 4/30/ 2. Name and Address of Facility	05	Hampstae	d, Md.
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neture1', or Items 23e or 28e-1 show emportent: If item 27 is marked other then "neture1', or Items 23e or 28e-1 show emportent: If item 27 is marked other then "other then profiled all once."		Land China E	line Funeral Home	<sup>K</sup> eisters	eisterstow stown, Md.	21136
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arrest	t,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final Issass or condition resulting in death)	<u> </u>			
ď	Examiner		Due to (or as a consequence of):	eusun			
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter 0 daryling Cause (Disease or injury				
	cuted nd ransit	Examine	that initiated events c.				
, 0,	ate be executed only sician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
8760,	certificate be executed nding physician and use as the burial-transit	dica	d				
) X 6	death certifica attending ph	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	ery
. Box	death e atter ed for u	iciai	in the past 12 months?  1 Nos 2 No. 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year
P.0	t the by th tache	hys	9 Unknown				
-	es tha igned be de	by F	Part II. Other significant conditions contributing to death but not resulting in the			cco use contribute to	
ord	v requires been sign should be	eted	A (-1) the position				
Vital Records	aw as E	Completed	A- JIB WILL RUNC		24a. Was an autopsy performe	prior to co	opsy findings available empletion of cause of
alF	Th ate pag		Venenta:	20 Pl / P /		I □ Yes	2 No
		o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death ont 3 DOA Other: 4 Nursing Hom		ce 6 ∏Other (Speci	fv)
of		-	27. Manner of Death 28a. Date of Injury 28b. Time		8d. Describe how		
ion	E 2 & 2	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	of or Attendate death I Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	8f. Location (Stre City or Town,	et and Number or Rur State)	al Route Number,
	pitel or ours afte erel Dir		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and alone as	ad due to the com	sea(e) and manner as	stated
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or i and manner stated.				
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month)	Day, Year)
)	1		And Ardel un	139502 MJ	•	4/4/10	
Ì	3		30 Name and address of person who completed cause of death (Item 23a) (Type	Print) ast Hain St. We	estmin	ter My	21157
	St	ate	31. Date filed (Month. Day Year) 32 degistrar's Signature	, , , , , , , , , , , , , , , , , , , ,			
	Regist		MAY 0 2 2005 there &	and a second			

			1- State of Maryland / State of Maryland /	Depa Cer	artment of Health and tificate of Death		giene () (Reg. No.	5 14785					
ı	Physicia		1. Decedent's Name (First, Middle, Last)  KARI POWEII			2. Date of Dea Month	ath Day	Year 2005 1:45 p. M,					
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea	th	4c. County						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	birthday)	Buttimere If Under 1 Year If Under 24 Hrs	8. Date of Birt	n Ma	9. Birthplace (State or Foreign					
	Director		212 10/1/3 12M 20F 87	Yrs.	Months Days Hours Min	8. Date of Birt (Month, Day		Country)					
	yland 10w		Usual Residence of Decedent  10a. State 10b. County 10c. City, To					10d. Inside City Limits					
	8e-fs	Director	Mo N/a Bont	mer				1 Tes 2 No					
	in ratural; or flema 23a or 28e-f show ledical Examinational be multiped at		10e. Street and Number  401 F 25th 3t Ant 27		10f. Zip Code 21218		10g. Citizen of What Country?						
		Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of Hispanic Origin? (sf Yes, specify Cuban, Mexican, Puer	Specify Yes or No-		e - American Indian, k, White, etc.					
0000	hours after tural', or ite	by Fu	1 Never Married 2 Married 1 Yes 2 Never Married 3 Widowed 4 Divorced Year or Dates:		1 ☐ Yes 2 ☐ Ne Specify:	to riball, dio.,	Cannife						
	72 hou natura	eted	15. Decedent's Education (Specify only highest grade completed)	ndkina	16h Kind of Business/Industry								
7	with ene. than	Be Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Sules mes									
ט ס	e filed al Hygi cother vent, I		17. Father's Name (First, Middle, Last)		OLES MEN 18. Mother's Na	me (First, Middle,							
ylan	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.	To	Guldie Poweil			1 EIKS							
Z Z			19a. Informant's Name/Relationship (Type, Print)  19  19  19  19  19		ng Address (Street and Number or R	fural Route Numbe							
ore,		-	20a. Method of Disposition 20b. Place cemei	of Dispos etery, cren	sition (Name of natory or other place)	Date	20c. Location -	City or Town, State					
altimor			4 □ Donation 5 □ Other (Specify) GAS 8	ENMIGE	Name and Address of Facility B	23/05	Bothm	y MD					
n n			Synature of Funeral Service Liberises		11 H N Core 1175								
	cate be executed  /Medical Examiner the burial-transit		23a. Part1. Enter the disease, or complications that caused the death. Dishock, or heart failure. List only one cause on each line.			The state of the s		Approximate Interval Between					
			Immediate Cause (Final disease or condition resulting in death)	on	ra f du	ng		Onset and Death					
			Due to (or as a consequence	010		0							
		ılner	Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or injury the difference of the conditions)	1006									
,		Examiner	that initiated events resulting in death) Last  Due to (ords a consequence of):										
9/8		dical	· Hepa	177	75-C14,	fect	zon						
0		Physician/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy				23d Date	e of delivery					
, Box	death le atter		in the past 12 months?  1 Yes  1 Yes  1 Yes			Month Day Year							
J.	that the de ad by the a detached t		9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting	23e. Did to	bacco use contr	ontribute to the cause of death?							
Records,	iidan: The law requires that the death certifi certificate has been signed by the attending l rector, page 2 should be detached for use as	ed by		-1	1×Yes 2□No 3□Probably 4□Unknow								
eco		Completed				24a. Was autop	sy p	Vere autopsy findings available irror to completion of cause of					
		To Be Con	25. Was case referred to medical			1 ☐ Yes	2X No 1	leath? ☐ Yes 2☐ No					
t Vital	ysician: iis certific director,		examiner?  Other Specific Spec										
no no	ding Ph h. After thi funeral												
Division	Hospitel or Atten 4 hours after deat Funeral Director: ely filled in by the	Certification;	2 Accident investigation 2 Accident investigation 3 Sucide 6 Could not be determined on the determined of the determined										
			4   numicide   Duilding, etc. (Specify)   City or Town, State)										
		edical	29a. Certifler  (Check only one)  Check only one)  Check only one)  Check only one)  Check only one)										
	To the within 2 To the Complete	Me	29b. Signature and little of certifier		29c. License number	71		(Month, Day, Year)					
	0		Much my	(a) /T	V +339		4-7						
	1		30. Name and address of person who completed cause of death (Item 23a	a) (Lype,	Caven 131	vd, 1	Sath	more M2/23					
	Sta Registi		31. Date filed (Month, Day, Year)  32. Registrar's Signature	Speed	W.								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** A CALL 2005 12.40P.M Ruth M. Ritz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner APUNDER (JEM BUPNIE ANNE NOPTH HOSPITAL ARUNDE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreig Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2XX Months Davs Hours Director 216-28-2672 April 10, 1932 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is markad other than "natural", or itams 23e or 28e-f show other traumatic svant, the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2√No Maryland Baltimore Direct Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2815 Illinois Ave Baltimore, MD 21227 21227 Funeral <u>United States</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 TVNo If Yes, Give Year or Dates: ☐ Never Married 2 ☐ Married ģ 1 ☐ Yes 1 No Specify: ¥Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within 72. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "na any injury or other traumatic avent, The Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Silk Screening
18. Mother's Name (First, Middle, Maiden Surname) Manufacturing 17. Father's Name (First, Middle, Last) William Riley Virginia Riley (nee Allison) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son - Gary Elliott 2815 Illinois Ave Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Memorial May 3, 2005 Glen Burnie, MD \* 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, here a cardiac or respiratory arrest, shock, or heart failure. List only/one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC LUNG CANCEIZ /Medical Due to (or as a consequence of): Examiner CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 No 1 Yes 2 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3∏ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After Hospitei or Attanding 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a Funaral [ 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 the 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) D.45,49 Mic) completed cause of death (Item 23a) (Type Print) 30. Name and address of person who ONABATO Glen barnie 130L DOSAtal MIS 21061. DYIVE 31. Date filod (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 0 2 2005

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year 1:25 PM 00 28 APRI 2005 /Medical Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** nion Hospita mor If Under 24 Hrs. 5. Social Security Number 8. Birthplace (State or Foreig **Funeral** Days Months Hours Min. 84-943 1 □ M 2 🕽 F Director March 22,1966 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits other traumatic avant, the Medical Examiner must be notified at 1 Yes 2 No Maryland **Funeral Director** mol 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23e or 2 Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 2 **S**(No Baltimore, Maryland 21215-0036 1 Yes 20 No Specify: þ Specify: 3 ☐ Widowed 4 ☑ Divorced Year or Dates "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than ondary (0-12) College (1-4or 5+) marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be f Department of Health and Mental F Important: If itam 27 is marked of 19a. Informant's Name/Relationship (Type, Print) (mother) 19b. Mailing Address (Street and Number or Rural Route Number, City State, Zip Code) 20b. Place of Disposition (Name of Md. 2121 Green 10 Date 20a, Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place; Cemeter 22. Name and Address of Pacility 21. Signature of Funeral Service/Licensee Joseph 22221 W. North Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart fail Physician SEPSIS disease or condition resulting in death) 5 DAYS /Medical Due to (or as a consequence of) **Examiner** AIDS 5 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. the attending physician by Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy for Month Year Day 5 Other (specify) 4 Pregnant at time of death ☐Yes 2☐No detached 9 Unknown 9 X Unknown ģ been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an Jas page 2 this certificate 1 ☐ Yes 2 **3** No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 1 🗌 Yes 2 **3**00 1 Minpatient 2 ER/Outpatient 3 DOA funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural Injury 1 TYes 2 No 2 Accident filled in by the Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide thin 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 2 APRIL, 28, 2005 MD ama AT2438946-E37

. State Registrar PARUL

31. Date filed (Month, Day, Year) MAY 0 2 2005

AGARWAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 201 EAST UNIVERSITY PARKWAY, BALTIMORE, MARYLAND 21218

32. Agistrar's Signature

Signature

			For State Registrar	State	of Ma	arylan		artmen rtificat			and M	ental Hy	/gier Reg. N	001	05	T COLUMN TO THE PARTY OF THE PA	88	
	Physici	an	1. Decedent's Name (First, Midd									2. Date of De Month		Day	Year	3. Time o		
1	/Medic	al,	Richard R. Reidenbach  4a. Fecility Name (If not institution, give street and number)  4					April					27	-		7:15	P M	
	Examin	er	Suburban Hospital					4b. City, Town, or Location of Death  Bethesda						4c. County of Death Montgomery				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Intropretant: If item 27 is marked other than "natural, or items 23a or 28a-f show any injury or other traumatic event. It is Medical Exactinate the radiible at one.		5. Social Security Number	6. Sex		e (In yrs.	last birthday)	If Under		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth			place (State untry)	or Foreign	
			203-07-4317	1 X M 2□	F 8	31	Yrs.	IVIOTIUIS	Days	- Hours		December 17, 1923 Pennsylvania						
			Usual Residence of Decedent  10a. State 10b. Count			10c. Cit	y, Town or La	cation						10d. Inside City Limits				
		tor	Maryland Mont	gomery		Po	tomac									1 🗌 Yes	s 2X No	
		Director	10g. Street and Number 10f. Zip Code 10g. Citizen of Wha								What Co	untry?						
		alD	11710 Smoketree Road 20854 United							Stat	es							
		Funeral	11. Marital Status		forces?		.S. 13.	Was Deced f Yes, spec	ient of Hi cify Cuba	spanic Ori n, Mexican	gin? (Sp 1, Puerto	ecify Yes or No Rican, etc.)	0-		ace - Amer ack, White	ncan Indian, , etc.		
36		by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give WW II 1 ☐ Yes 2 ☐ No Specify: Year or Dates:								Spec	ify: Wh	ite					
Maryland 21215-0036		ted		nt's Education			16a. Dece	dent's Usua	I Occupa	ation	A = 6= de		16b.	Kind of I	Business/i	ndustry		
218	thin 7 e. an "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  5+  (Give kind of work done during most of working life. DO NOT use retired)  Certified Public Accountant						partment of Health									
2	l be filed wi ntal Hygien ed other th		47 Cabada Nama / Cara Middle	5+			Certi	tied	Publ							ervice	9	
and		Be c	17. Father's Name (First, Middle Abner S. Reid									e (First, Middle	, Maide	an Suma	me)			
Ž	should nd Me mark mark	To.	19a. Informant's Name/Relation				19b. Mailir	ng Address	(Street a			Rohrer al Route Numb	er, City	y or Town	n, State, Z	ip Code)		
S	ss 1 and 2 s of Health ar item 27 is r other trau		Richard J. Re	idenbach	/ Sor	n	11710	Smol	cetre	ee Ro	ad,	Potomac	e, M	1ary]	Land	20854		
ore,			20a. Method of Disposition 1 🕅 Burial 2 □ Cremation	3 DRomoval fr	om Stata	20b. F	Place of Dispo	sition (Nar natory or o	ne of ther plac	в)		Date	20c.	Location	- City or T	Town, State		
Ĕ	Pag ment ant: i		'4 Donation 5 Other (		OIII State	Parl	klawn Mer					2005						
Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service	Licensee	co NA	M013	156 Ro	Name an ockvi ockvi	d Addres Lle, Lle,	is of Facilit Inc. Mary	y Ro 500 1and	bert A. West N 20850	. Pu lont	imphr :gome	rey F	uneral venue,	Home	
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that only one cause	at caused on each lir	the deat	h. Do not ent	er the mod	e of dying	g, such as	cardiac	or respiratory a	arrest,			Approxima Interval Be Onset and	tween	
	death certificate be executed /Medical Examiner   Medical Examiner   M		Immediate Cause (Final disease or condition resulting in death)	- u.			rdiomy	opatl	ıy							3 year		
							uence of):	•										
		Jer	Sequentially list conditions, if any, leading to immediate	b. Co	ronar to or as	a cons	tery D	1seas	se							20 yea	rs	
		Examiner	cause, Enter Underlying Cause (Disease or injury that initiated events  cAtherosclerotic Cardiovascular Disease								40 yea	rs						
, 0		I Ex	resulting in death) Last Due to (or as a consequence of):															
8760,	physic the b	dical		d														
)х 6	teath certific attending p	/Me	IF FEMALE:	23c. If yes,	outcome	of pregna	ancy							23d D	ate of deliv	/erv	-	
Вох	death atter	iciar	23b. Was decedent pregnant in the past 12 months?  1							Month Day Year								
Ö.	that the de led by the a detached t	hysi	9 ☐ Unknown															
rds, P	aw requires is been sign 2 should be	ed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use con  1 Yes 2 No											death? JUnknown				
Division of Vital Record		plet	Renal Failure								24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of							
<u> </u>		Completed										perfo 1 ☐ Yes	ormed? 2X N	10	death? 1 ☐ Yes			
Vita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospitale					Othe		of Deat	Check only	one)					
of	ys dis	ertification: To	1 Minpatient 2 EMOutpatient 3 DOA 4 Nursing								Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred							
on	Attending Pfr r death. sctor: After thi by the funera		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury Work? 2 Accident investigation 28b. Time of Injury Work? 1 Yes 2 No															
Visi	or Attend after death Director: , in by the f	ifice	3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								ber or Rui	al Route Nur	nber,					
ō	itel or rs afte al Dir eo in	Cert	building, etc. (Specify)  City or Town, State)															
	To the Hospital or At within 24 hours after of To the Funeral Direction place in by	Medical	29a. Certifier 1X Certifyi (Check only one) 2 Medica	ing Physician: To I Examiner: On the	the best of ne basis of nanner sta	examina	wledge, death tion and/or in	occurred vestigation	at the tim in my op	e, date an	d place, th occurr	and due to the red at the time,	date a	nd place,	, and due	to the cause(	s)	
	To t To t	Σ	29b. Signature and little of certifi	ar A	, , ,				License					-		Day, Year)		
,	1/1		Many	MIO	M	-	4		16360	,			Apr	:11 2	29, 2	003		
30. Name and ad less of person who completed cause of death (Item 21) (Type, Print)  Samuel D. Goldberg M.D. 6410 Rockledge Drive, B								Rat	han	da Mo∽	371 a	nd ?	<b>0817</b>					
	Sta	te	31. Date filed (Month, Day, Year		Registra			age D	TIVE	, שכו	.1162(	ia, Mar	ута	110 4	001/			
š.	Registr		MAY 0 2			1.		1.319										

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4/27/05 Previdentach, Aictfacol 4.

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 1, 2005 **Physician** John Wesley Sedicum 1:05 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Baltimore Gilchrist Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 22 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**7**0 M 2□ F 82 Maryland 218-18-3212 Yrs Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State ral, or Itams 23a or 28e-f show Examiner rust be notified at 1 ☐ Yes 2 X No Baltimore Owings Mills Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 132 Cedarmere Rd. 21117 Funeral 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bfack, White, etc. 1 Never Married 2 Married Specify: White 21215-0036 1 ☐ Yes 2 No "natural", or Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: permit. Pages 1 and 2 should be filed within 72 ht. Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natur any injury or other treumatic event, I'm Medical pages. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Electrical Co. 12 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) John Jefferson Sedicum Marjorie Hedrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 132 Cedarmere Rd., Owings Mills, Md. 21117 Ruth C. Sedicum - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
1 4 ☐ Donation 5 ☐ Other (Specify) May 4, 2005 Carrolls Cemetery Timonium, Md. 22. Name and Address of Facility
Eckhardt Funeral Chapel, P.A. 21. Signature of Funeral Service 21117 11605 Reisterstown Rd., Owings Mills, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Merkel (ell Years **Physician** /Medical Due to (or as a consequence of) Yeavs **Examiner** Renal tailure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Due to (or as a consequence of) the attending physician Physician/Medicai The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? certificate has 2 No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of After Injury 1 Maturat 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Diractor: / completely filled in by the f death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature/and title of certifier May 1 2005 00061199 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) North Charles Street Touron Black 660I Jason 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

at

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year YO Ump 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** albeth timore VIVSIMA Center 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 250 F 218-18-0851 83 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "neturel", or items 23e or 28e-f show other treumatic event, the Mcdical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 207 1st Ave. S.W. 21061 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Never Married 2 Married 1 Yes 2 No If Yes, Give XX Year or Dates: Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes ŽŽNo Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Packer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental h should be John E. Stumpf, Sr. Mildred J. Peddicod 2 permit. Pages 1 and 2 sh.
Department of Health and .
Importent: If item 27 is ma. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Stumpf, Jr. / Brother 289 Thelma Ave. Glen Burnie, MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) May 2, 1 

■ Burial 2 

□ Cremation 3 

□ Removal from State Glen Haven Mem. Pk. ° 4 □ Donation 5 Other (Specify) 2005 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee Kirkiey - Ruddick Funeral Home P.A. X. | 421 Crain Hwy. S.E. Glen Burnie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only line a use on lack line. Approximate use on ach line Interval Between Onset and Death Immediate Cause (Final **Physician** ronav disease or condition resulting in death) Zari /Medical Due to (or as a consequence of): **Examiner** neumon Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as attending 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy ŏ in the past 12 months?
1 Yes 2 No Month signed by the at d be detached fo 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Winknown 1 Tyes 2 No should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1 Yes 2□ No 1 TYes or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MID 30. Name and address of person who completed care of death (Item 23a) (Type, Print) Benson Avenue, Bultimore

State Registrar

31. Date filed

33

(Maple Day Year) 2005

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Registrar State of Maryland / Department of Health and Mental Hygiene Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 4 **Physician** quendolyn 27 2005 17: 58PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 M 2 F Days Hours Director the Maryland Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23e or 28e-f shor traumetic event, the Mudical Exprimer must be notified #1 AUTIMORE 1 Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-ban, Mexican, Puerto Rican, etc.) American Indian filed within 72 hours after 1 Never Married 0. Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: ģ 3 Widowed 4 Divorced "natural", Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry bartment of Health and Mental Hygiene.
ortant: If item 27 is marked other than
injury or other traumatic anam Elementary/Secondary (0-12) College (1-4 or 5+) IFACHER Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Pages 1 and 2 should be FON EDWARDS 19b. Mailing Address (Street and Number or Rural Route Number, 20b. Place of Disposition (Name of cometery, crematory or other p 20a. Method of Disposition permit. Page:
Department of Important: If any injury or once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee /ask 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespinatory arresponding. Approximate Onset and Death Immediate Cause (Final Pitysician Lung Cancer 4 months disease or condition resulting in death) /Medical Due to (of a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or in jury that initiated events Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day 4☐ Pregnant at time of death Month Year 5 Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check only one) examiner' 1 ☐ Yes 250 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 > Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sabrina N. Krata 4/27/2005 30. Name and address of person who completed ause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Sabrina N. Kratz

2. Registrar's Signature

South Greene Street Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#/ perFH G843.5/1//05 TI
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 3. Time of Death A Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month, **Physician** DI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Winc hester N59.( Town Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Month, Day, Year) APr'i 16,1920 Birthplace (State or Foreign
 Country) **Funeral** 5. Social Security Number 6. Sex Days Months Min. 14-706 100 M 2□F 85 Yrs. Mary Director land Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23s or 28e-1 show any injury or other traumatic event, its Medical Examiner must be notified at 900s. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Director imor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Manor Completed by Funeral 10 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Malac ဂ္ Cousin) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gobe) 21215 50 Johnson 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Crematory 516 Metro 12005 \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Joseph L. Russ Funeral
2222 W. North Ave. Batto. 21. Signature of Funeral Service Licensee Home Ma. 2 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoty, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as Box 68760. use as the attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. certificate has been signed by the a rector, page 2 should be detached 9☐ Unknown 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2. No 1 🗌 Yes 2. No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the ( 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) < rue 30. Name and address of person who completed cause of deat\* (Item 23a) (Type, Print) B. MVEL 413 Conk lille, up Willie

Registrar

State

31. Date filed (Month, Day, Year) MAY 02

32.

2005

			For State Registrar	State of Mar	yland / Depa	artmen		and M	ental Hyg		9. 05  4793
			1. Decedent's Name (First, Middle, Last	)					2. Date of Deat	h	3. Time of Death
	Physici		Eugene Joseph	Shanahan	Sr.				4 Month 2	28 2005	3:00 PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City.	Town, or Location	on of Death		4c. County of E	
	CXAIIII	lei	1016 Cayer Drive			1	n Burnie			Anne A	
	Function		Social Security Number 6. Se		In yrs. last birthday)			ler 24 Hrs.	8. Date of Birth		
	Funeral Director			M 2□F	74 Yrs.	Months	Days Hour	s Min.	8. Date of Birth (Month, Day, 8-17-19	Year)	Birthplace (State or Foreign Country) MD
			Usual Residence of Decedent			1 1			0-17-13	750	PID
	land S Mand		10a. State 10b. County	1	Oc. City, Town or Lo	cation					10d, Inside City Limits
	Man	jo	MD Anne Aru	nde1	Glen Bu	rnie					1 ☐ Yes 2 📉 No
	288 288	ec	10e, Street and Number			10f. Zip	Code		1	0g. Citizen of Wha	t Country?
	with so	by Funeral Director	1016 Cayer Drive				21061			USA	·
	eath m 23	era	11. Marital Status	12. Was Decedent Ev	erin U.S. 13	Was Dece		Origin? (Spe	ecify Yes or No-		American Indian,
	ter d stan	Ë	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 🛣 No	0	If Yes, spec	dent of Hispanic orly Cuban, Mexic	can, Puerto	Rican, etc.)		White, etc.
36	rs af	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2⊠No Speci	ify:		Specify:	white
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itema 23e or 28a-f show ha Medical Examinar must be notified at	ed	15. Decedent's Edi		16a. Dece	dent's Usua	al Occupation			16b. Kind of Busin	ess/Industry
15	in 72	Completed	(Specify only highest grad	ie completed)	(Give	kind of wor	rk done during m se retired)	ost of worki	ng		out madely
12	filed with Hygiene. other ther	E	Elementary/Secondary (0-12)	College (1-4or 5+)		arpeni				Constr	uction
	filled Hygie other		17. Father's Name (First, Middle, Last)			ar peni	T	ther's Name	(First, Middle, I	Maiden Sumame)	
an	Mental Mental Arked o	Be c	John Francis Sh	anahan			Va	thryn	Irene	Parara	
7	2 should and Men is marks sumatic	2	19a. Informant's Name/Relationship (T		19h Maili	na Address				Brown City or Town, Sta	te Zin Codel
Maryland	d 2 s th an 17 is trau		Mrs. Patricia G. S						Burnie,		
e,	1 and Health em 27 ther to		20a. Method of Disposition	mananan, wi	20b. Place of Dispo	sition (Nan	ne of			20c. Location - City	
آو	Peges net of I int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ I		cometery, crea Chesapeak	matory or o	ther place)	5/2/		Stevensv	
Baltimore,	t. Pertiner		21. Signature of Funeral Service Licens								
Ba	permit. Peges 1 and 2 should be filled within 72 hours after death with the Marylar Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23e or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at ODEs.		Mac ( A)		1261		nd Ave S			Funeral MD 2106	Home P.A.
	Physician /Medical		23a. Pert 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	· Meta	te death. Do not ent	Pa o	e of dying, such	as cardiac o	r respiratory arro	est,	Approximate Interval Between Onset and Death I M M //
760,	eath certificate be executed attending physician and for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	b. Emphi Due to (or as a)	consequence of):	(bes					5 years
876	ate b hysic the b	Ilcai	•	d							
.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetel death 3	Ectopic pr				23d. Date of Month	delivery Day Year
ds, P.	signed b		Part II. Other significent conditions co	ntributing to death but	not resulting in the u	nderlying c	ause given in Pa	rt I.	23e. Did tob		te to the cause of death?  Probably 4 Unknown
Ö	w require	ete							04-146		
Il Records,		Completed by							24a. Was a autops perform	prior deat	e autopsy findings available to completion of cause of h? Yes 2 2 De
Vital	Physician: this certifical	Be	25. Was case referred to medical examiner?					ace of Death	(Check only on	e)	
of	Physic this o	0	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 🗆 DO	A Other: 4	Nursing Hor	ne 5 Aeside	ince 6 Other (	Specify)
n c	ng P fter ti		27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	28b. Time o	1 2	8c. Injury at Work?	1	28d. Describe ho	w injury occurred	
<u>Ö</u>	death. ctor: Aft y the fun	atle	2 Accident investigation			М	1 ☐ Yes 2	□No			
Division	Hospitef or Attending 24 hours after death. Funerel Director: After tely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	- At home, farm, sti (Specify)	reet, factory	, office	4	28f. Location (St. City or Town		r Rural Route Number,
	To the Hospitel or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	Medical (	29a. Certifier 1 Certifying Phy (Check only one)	rsicien: To the best of iner: On the basis of eand manner state	xamination and/or in	h occurred vestigation,	at the time, date, in my opinion, d	and place, a leath occurre	and due to the ca	suse(s) and manne ate and place, and	or as stated. due to the cause(s)
	To the within 2 To the comple	W	29b. Signature and little of certifier	00	/	29c	. License numbe	)r	2	9d. Date signed (M	fonth, Day, Year)
	1 /		\$ 9/1/1HI	Klines			02000	14		04/29/	1
1	6		30. Name and address of person who c	ompleted cause of alea	th (Item 23a) (Tyne	Print)			- :	10110	J
1	y		Elleott Herba	Ky MD, 141	1 Made	son	Park 1	Drive	Glen	Burnie	44,206/
13	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar'. 2 2005 <b>▶ Cla</b>	Solgnature &	Good		,		ī	,

			For State Registrar	State of Marylar		artment of H		Reg.	2000	14791
	hysicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last, Alfred L. Shipp  4a. Fecility Name (If not institution, give St. Mary's Hospit	street and number)		4b. City, Town, or Leonardt		2. Date of Death Month APRIL 23.	Day Year 2005 4c. County of Dea	
	ineral rector		5. Social Security Number 6. Sec. 217-38-1376		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye		thplace (State or Foreign ountry) ginia
within 72 hours after death with the Maryland ene.	Sa-f show officed at	ector	Usual Residence of Decedent  10a. State 10b. County  MD St. Mar	1	ty, Town or Lo	rdtown				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
death with t	ms 23a or 2 must be n	Funeral Director	10e. Street and Number 22810 Dorsey Stre	et #312  12. Was Decedent Ever in U	J.S. 13.	10f. Zip Code  206  Was Decedent of His If Yes, specify Cubar			. Citizen of What C  USA  14. Race - Am	
ours after o	urai', or iter I Exar diner	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced	1 XYes 2 No If Yes, Give Year or Dates: 158 -		If Yes, specify Cubar 1 ☐ Yes 2X No	Specify:	Rican, etc.)	Black, Whi	
within 72 h lene.	than "natu the Mudica	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of worl	sing 16t	drywa:	,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.	arkad other atic event, I	To Be C	17. Father's Name (First, Middle, Last) Charles Kennet	h Sh <b>i</b> pp				e (First, Middle, Mai e Elizabe	iden Sumame)	L L
oermit. Pages 1 and 2 should be filed within 72 hours aft Jepartment of Health and Menial Hyglene.	sm 27 ie ma thar traume		19a. Informant's Name/Relationship (Ty Tammy Douglas/daug 20a. Method of Disposition	hter	523		es Stree	t Elkton,	MD 2192	21
nit. Pages artment of I	ortant: if ite injury or o' g.		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  '4 ☑ Donation 5 ☐ Other (Specify)	lemoval from State	cemetery, crei	matory or other place  2. Name and Addres.	s of Facility		c. Location - City or	
Dep	any is		21. Sunatur of Euneral Service Licens Ronal d S.  23a. Part Enter the disease, or compleshoot, or heart failure. List only or	ications that caused the dea	r S	tate Anato altimore,	omy Board MD 2120	1 655 W. B		Street  Approximate Interval Between
Ame Examined executed	physician and dical street prices and prices and prices are the prices and prices are the prices and prices are the prices are	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect of the conse	bled	recta				Onset and Death
the death certif	ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of of 9 Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	blivery Day Year
The taw requires that the	should be deta	ρ	Part II. Other significant conditions con	ntributing to death but not re	u ent ni gnitlus	nderlying cause give	n in Part I.	23e. Did tobac 1 ☐ Yes		o the cause of death?
	ate has page 2	Completed						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of s 2 \sum No
Physician:	s certil directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 XInpatient 2	ER/Outpatier	othe	PI.	th (Check only one) ome 5 - Residence	- C CIOther (C-	
Attanding Phy	To the Funeral Diractor; Atter this certific complataly filled in by the funeral director,	Certification: T	27. Manner of Death 1 Xelatural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury Work	at	28d. Describe how i		ruiy)
Hospital or Atl	erai Diract		4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)			28f. Location (Stree City or Town, S	itate)	
To the Hospital within 24 hours a	e Fun lataly	edical	(Check only 2 Medical Exami	sician: To the best of my kn ner: On the basis of examinand manner stated.	ation and/or in	n occurred at the time vestigation, in my op	e, date and place, inion, death occur	and due to the caus red at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
To th within	To the	Me	29b. Signature and title of certifier	irah		29c. License	1706		Date signed (Mon	
34	Sta	te	30. Name and address of person who of DR. A.D. SHAH 2265 31. Date filled (Many) Pay (2ar) 2005	O CEDAR LANE	COURT		WN, MD 2	0650		

ALFRED LYNN SHIPP

State Registrar

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

Dr. Mutombo Kankonde 1221 Mercantile Lane Largo, MD 20774 32. Regitrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 0 2 2005

31. Date filed (Month, Day, Year)

		1	For State Registrar	e of Maryl	-	artment of H		Mental Hygie	ene 005	14796
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al -	Lorra			Snyder		April 27	, 2005	7:15 A <sup>M</sup>
	Examin	_	4a. Facility Name (If not institution, give street ar	nd number)		4b. City, Town, or Dunda		n	4c. County of Dea	
			1743 Portship Road  5. Social Security Number 6. Sex	7 Age (In	yrs. last birthday)	If Under 1 Year		8. Date of Birth	9 Ri	nthplace (State or Foreign ountry)
	Funeral Director		214-26-7376		Yrs.	Months Days	Hours Min.	(Month, Day, ) Sept. 7,		ountry) ryland
	ס	-	Usual Residence of Decedent		O1					10d. Inside City Limits
	arylar show		10a. State 10b. County		. City, Town or Lo	cation	Dund	-1k		1 ☐ Yes 2 ☐ No
	the M	ecto	Maryland Baltimore	е		10f. Zip Code	Durid		g. Citizen of What C	ountry?
	Mith Ba or	급	1743 Portship Road				21222	ī	Jnited St	ates
	within 72 hours after death with the Maryland one. Then "naturel", or Items 23a or 28e-f show the Modical Examiter man be notified at	Funeral Director		Decedent Ever	in U.S. 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or No-	14. Race - Am Black, Wh	
9	or Ite	E.	1 Never Married 2 Married 1 If Ye	Yes 2 No s. Give		1 ☐ Yes 2 ☒ No	Specify:	10 (110an, 010.)	Specify:	White
21215-0036	hours urel',	d by	3 ☐ Widowed 4 ★ Divorced Year  15. Decedent's Education	r or Dates:	16a Dece	dent's Usual Occup	ation	11	3b. Kind of Business	
-5	in 72 "nat	Completed	(Specify only highest grade compl		(Give	kind of work done of DO NOT use retired	durina most of wo	rking	D. Tana of Daomoo	andaooy
212	d with	mo	Elementary/Secondary (0-12) Colt 6 Years	ege (1-4or 5+)	Но	memaker			Own Hom	e
pu	2 should be filed within and Mental Hygiene. is marked other then eumatic event, Ire M.	Bec	17. Father's Name (First, Middle, Last)					me (First, Middle, Ma		
yla	shoutd tand Ment smarked	ပ္	Oscar Corrie					tta Hartm		Zi- Codel
Maryland	12sh hand 7ism treum		19a. Informant's Name/Relationship (Type, Prin Gloria McCoy (Grandd	-		ng Address <i>(Street)</i> 5 Orville		ural Route Number, ( altimore,		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene. Importent: If item 27 is marked other then "naturet", or Items 23a or 28e-f show emportent: If item 27 is marked other then "naturet", or Items 23a or 28e-f show empirioury or other treumatic event, the Modest Examiner mast be notified at once.	1	20a. Method of Disposition		Db. Place of Dispo	osition (Name of matory or other place	a)	Date 20	c. Location - City o	r Town, State
ē	Pages nent of nnt: If its nry or o		1 ☐ Burial 2 【Cremation 3 ☐ Removal • ♣ Donation 5 ☐ Other (Specify)	9/2005	Towson, M	aryland				
Baltimore,	Departm Departm Importer eny inju		21. Signature of Funeral Service Licensee	//	the state of the		and the second s	Home of	Dundalk.	Inc.
<u> </u>	99 1 9		1)c~ (. (	and		7922 Wise	e Ave. Di	undalk, Ma	aryland :	21222
	Pnysician		23a: Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition	that caused the e on each line.	death. Do not en	ter the mode of dyin	ig, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	ue to (or as a o						
		er	Sequentially list conditions, if any, leading to immediate	ue to (or as a coi	nsequence of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							-
0,	certificate be executed ding physician and use as the burial-transit			ue to (or as a co	nsequence of):					
8760,	cate b	dlca	d							
9 X	eath certific attending pl	/Me	IF FEMALE: 23c. If yo	es, outcome of pr	egnancy				23d. Date of de	elivery
Вох	atter for u	Physician/Medical	in the past 12 months?	Live birth 2 🗌 Pregnant at time		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	/ 		Month	Day Year
P.O.	that the c ed by the detached	hys	9 ☐ Unknown	Unknown						-
	nrequires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing	g to death but no	t resulting in the u	underlying cause giv	en in Part I.	23e. Did toba		to the cause of death?  Probably 4 Unknown
000	law req as beel 2 shou	Completed						24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
Re	The ta	mo						perform	ed?// death?	
ita	ilcien: The lav certificate has rector, page 2	Be	25. Was case referred to medical examiner?			104		ath (Check only one	)	
of V	this all dill	2	1 ☐ Yes 2 XNo Hospital	1 U Inpatient	2 ER/Outpatie		4   Nursing I	Home 5 Resider		ecify)
ou c	ding After fune	tlon	Zyratulai S_1 oliding	Date of Injury (Month, Day Ye	ar) Injury	Wor	k? Yes 2 □No	25d. Describe nov	v injury occurred	
Division of Vital Records,	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Certification:	2 Accident	Place of Injury - building, etc. (S	At home, farm, si pecify)	reet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	Hospitel or 14 hours afte Funerel Dir tely filled in	Ce	29a. Certifier i Certifying Physician:	To the hest of m	v knowledge, dea	th occurred at the tir	me, date and plac	e, and due to the car	use(s) and manner	as stated.
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	(Check only 2 Medical Examiner: Or	the basis of exa d manner stated.	mination and/or i	nvestigation, in my o	ppinion, death occ	urred at the time, da	te and place, and du	ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens			d. Date signed (Mor	
	4		1/8	)		1700	55992	,	04/27/0	95
1	7		30. Name and address of person who complete	d cause of death	(Item 23a) (Type	Print)	BAIX	irmere P	10 3123	2
	St	ate	31. Date filed (Month, Day, Year)	32. Flegistrar's	Signatur	Print)	C 15/11	11 21 2 ,		
	Regist		MAY 0 2 2005	Hirew.	, ,,,	`				

			For State Registrar		State	of Mary	land / Depa	artment e rtificate			nd Me		giene Reg. No.	. UU:	5	14797
			Decedent's Name (First	t, Middle, Last	)						2	2. Date of De	ath			3. Time of Death
	Physicia /Medic		Holly	7			Taylo	or				Month 4	20 Day	200°	ar 5	12:Noon
	Examin		4a. Facility Name (If not in		street and n	u <i>mber)</i>		4b. City, To	own, or	Location of	Death		4c.	County of E	eath	
			614 Main S	treet						r Sta				Balt	imo	re
	uneral		5. Social Security Number		x ]M 2 <b>⊠</b> F		yrs. last birthday) Yrs.	If Under 1 Months [	Year Days	If Under 2 Hours	Min.	Month, Da	y, Year)	1	Count	
D	irector	-	439-67-4484 Usual Residence of Deced	±		32	113.		1			11 8	191	72	Mis	sour
land	M H			County		100	c. City, Town or Lo	ocation							10	d. Inside City Limits
Man	Hed.	ţo	MD E	Baltimo	re		Turner	Statio	n							1 ☐ Yes 2 <b>X</b> No
th the	or 28s	irec	10e. Street and Number			•		10f. Zip C	ode				10g. Citi	zen of What	Count	ry?
th w	23a (	Funeral Director	614 Main S	Street				21	222					U	SA	
ar dea	tems	nue	11. Marital Status		Armed F		in U.S. 13.	Was Deceder If Yes, specify	nt of His y Cubar	spanic Origi n, Mexican,	n? (Speci Puerto Ri	ify Yes or No- can, etc.)	-	14. Race - A Black, V		
s afte	Contract	by F	1 Never Married 2 3 □ Widowed 4 □ D		1 □ Yes If Yes, G Year or			1 ☐ Yes 2 ☐	XNo	Specify:				Specify:		D. 1
3 no	atural cal E		15. D	ecedent's Edu	cation		16a. Dece	dent's Usual (	Occupa	tion			16b. Ki	nd of Busine	ss/Ind	Black ustry
o vic	n n	Completed	(Specify only	y highest grad	e completed	(1-4or 5+)	(Give	kind of work DO NOT use	done di retired)	uring most	of working	7				,
d with	ar the	E O	Elementary/Secondary	(0-12)		ears	Di	sabled						N/A		
<b>3 2 3 3 3 3 3 3 3 3 3 3</b>	d oth	Be (	17. Father's Name (First,	Middle, Last)						18. Mother	s Name (	First, Middle,	Maiden	Sumame)		
at yildilid XIXISTOOOO should be filed within 72 hours after death with the Maryland	arkec atic e	2	Hollis W	V. Ta	ylor	Sr.					ace	H.		rison		
2 sh	Is m		19a. Informant's Name/Re		quai	rdian		ng Address (S					er, City o		·	Code)
1 and	Department of result and wenter rygience.  Unportent: If them 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Markinal Examinal initial be indiffied at once.		Sister Mary 20a Method of Disposition		Chine		Ob. Place of Dispo	Gunn I		d Cat	onsv.		MD 20c Lo	2122 cation - City	•	on State
5 %	or or		1 ☐ Burial 2 ☐ Crer	mation 3 🗆 F	Removal from		Broder (	matory or othe	er place							
ii. P	orten injury		° 4 □ Donation 5 □ C					2. Name and			4-2	8-05 Balt		cnar e, Md.		Missouri 21202
Dermin Da	Important in once.		212	adem	W	man	0-0	March			t	1101				.1202
	7		23a. Part1. Enter the dise shock, or heart failu	ease, or compl	ications that	caused the	death. Do not en	er the mode of	of dying	, such as c	ardiac or i	respiratory ar	rest,			Approximate Interval Between
Phy	ysician		Immediate Cause (Final disease or condition	ie. List offiy o	ne cause on	1:	La 6	5								Onset and Death
/N	ledical		resulting in death)		a	o (or as a co	nsequence of):								-	- 400.
Ex	aminer		Sequentially list condition	ns.	b											
pe	ti s	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	ate 4	Due to	o (or as a co	nsequence of):									
xecut	and Il-tran	хап	that initiated events resulting in death) Last		cDue to	o (or as a co	nsequence of);								-	
cate be executed	physician and s the burial-transit	dicai E		ı,	d											
	g phy:	edic		- 1	J											
OI VII DECOLUS, T.O. BOX of Physicien: The law requires that the death certifi	attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregr	nant 2		utcome of pr		Ectopic preg	nancu				2	3d. Date of	deliver	,
deat	e atte	sicia	in the past 12 month 1 ☐ Yes 2 ☑ No	ns?		gnant at time		Other (spec						Month		Day Year
at the	by the	hys	9 Unknown						_	<del></del>		T				
uires th	been signed by the attendin should be detached for use	by	Part II. Other significant	conditions co	ntributing to	death but no	t resulting in the u	nderlying cau	ise give	n in Part I.						cause of death?
in bear	hould	eted	199	1	7 7 1	2 3						-				
e law	has b	Completed	nyp	e- 1 '	PIU	en,	0					24a. Was autop		24b. Were prior death	to com	sy findings available pletion of cause of
<b>5</b> 5	ficate r, pag		der	mes;	100							1 ☐ Yes	2 No	101	es 2	2□ No
VII Sicien:	certi	o Be	25. Was case referred to examiner?  1 ☐ Yes 2 ▼ No	-	Hospital:	Inpatient	2 ER/Outpatier	at 20 00A	Othe	-		Check only o		Other (9	naciful	
2 5	er deam. rector: After this certificate has by the funeral director, page 2	<del>  </del>	27. Manner of Death		28a. Dat	e of Injury	28b. Time o		: Injury Work			d. Describe h			pocity)	
SIOIS tending	deam. ctor: Afte y the fun	atio	2 Accident	Pending investigation	(MC	nth, Day Yei	ar) Injury	М		es 2□N	0					
Z Alle	affer deam I Director: / d in by the f	Certification;	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Plac	ce of Injury - ding, etc. (S	At home, farm, str	eet, factory, c	office		28	f. Location (S City or Tox	Street and	d Number o	Rural	Route Number,
le le	re and re led in															
Hosp	Fune Fune tely fi	edicai	29a. Certifier 1 Check only 2 N	Certifying Phy Medical Exami	ner: On the	ne best of my basis of exa inner stated.	y knowledge, deat mination and/or in	h occurred at vestigation, in	the time my op	e, date and inion, death	place, an	d due to the d at the time, d	cause(s) date and	and manner place, and	as sta	ted. he cause(s)
To the Hospitel or Attending	within 24 hours and To the Funerel Dis completely filled in	Med	29b. Signature and May of	f certifier	and ma	Stated.	)	29c. L	License	number			29d. Date	signed (M	onth, D	ay, Year)
H :	s ⊢ ŏ		▶ X		~	wi	•	D	کر کر	76	P		AFR	21	. 2	005
1			30. Name and address of	person who co	ompleted ca	use of death	(Item 23a) (Type,						111		1	005
)			J corwi		0	4000	(Item 23a) (Type,	foils	s R	0	700	, Br	25	o my	2 -	11227
4 "	Sta		31. Date filed (Month, Da	y. Year) ' 0 2 20	05 32	Registrar's S	Signature	and a								
	Registr		[V) [-4, 7	V W ZU	HB   5%	Made and	AP AND	2000								

		State of Maryland / Departm	nent of Health and M	-		11.700
			cate of Death	Reg. 2. Date of Death	No. <sup>Sea</sup>	2 Time of Death
Physicia	an	1. Decedent's Neme (First, Middle, Last)  John S. Talasky		Month	Dey Yeer	3. Time of Death  5 • 20 A M
/Medic	al		City, Town, or Location of Death	April 27	4c. County of Death	5:20 A M
Examin	er	The state of the s	ddle River		Baltimore	3
Funeral Director		5. Social Security Number  6. Sex  1 № 1 7. Age (In yrs. last birthday)  1 № 2 □ F 64  7. Age (In yrs. last birthday)  1 № 1 № 1 □ F 64	Inder 1 Year If Under 24 Hrs. Inths Days Hours Min.	8. Date of Birth (Month, Day, Ye June 25, 1	g. Birthp Court 940 Mary	lace (State or Foreign land
pu ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				0d. Inside City Limits
shov	7	10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Middle Rive				1 ☐ Yes 2 ☑ No
the N 28a-f	Director	_	f. Zip Code	10g.	Citizen of What Cour	itry?
3a or	io ie	1 Manifold Ct.	21220		USA	
deat	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was D	Decedent of Hispanic Origin? (Spe , specify Cuban, Mexican, Puerto I	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
s after	by Fu	1 ◯X Never Married 2 □ Married 1 □ Yes 2 ◯X No II Yes, Give 1 □ Yes 3 □ Widowed 4 □ Divorced Year or Dates:	es 2 No Specify:		Specify: Whi	te
tural al Er		15. Decedent's Education 16a. Decedent's	Usual Occupation	166	. Kind of Business/Inc	
nin 72	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	of work done during most of workin OT use retired)	ng		
d with	Com	12 Lab	orer		Recycling	
Last y father Z. I.Z. I.D. DOOD 2 should be filed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland 1s marked other than "natural", or items 23s or 28s-f show sumatic event, the Marylan Examination initiation at	Be	17. Father's Name (First, Middle, Last)  Joseph Talasky	Anna Jed	(First, Middle, Mai Idery	den Sumame)	
n y 10 hould d Mer mark matic	ပ		dress (Street and Number or Rura		ity or Town, State, Zip	Code)
and 2 s and 2 s ealth an m 27 is i					, Md. 2102	
other		20a. Method of Disposition 20b. Place of Disposition cemetery, crematory	(Name of prother place)		. Location - City or To	wn, State
Pages ment of t ant: If its ury or o		1   Burial 2 □ Cremation 3 □ Removal from State  Most Holy Removal from State		2005 Ba	ltimore Ci	ty, Md.
Defitting 19, With yield Z. 12.15.0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menhall Hygiene. I importment of Health and Menhall Hygiene. I importants if than 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examination to the notified at once.		Bruz	ne and Address of Facility Zdzinski Funeral 7 Old Eastern Av	Home P.A	A. ex. Md. 21:	221
ate be executed /Medical Examiner he burial-transit	ical Examiner	23a. Parti. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only on course on ach line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C	wetve Rel	wond	ry Arles	Interval Between Onset and Death
X OO sertificat ding phy se as th	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	arv.
ine death certificate the attending physiched for use as the	Physician/Medic	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ector	pic pregnancy er (specify)		Month	Day Year
necolds, r.O. box 001 The law requires that the death certificate the has been signed by the attending physologe 2 should be detached for use as the	þ	Part II. Other significant conditions contributing to death but not resulting in the underly	ring cause given in Part I.	7573	co use contribute to the	
law recast bee	ompleted			24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
The law ate has page 2:	Com			performed 1 ☐ Yes 2X	1? death?	
VICIAN: ician: certifica	Be (	25. Was case referred to medical examiner?	Other	(Check only one)		
Physi Physi rthis c	-T	1 ☐ Yes 2 🔀 No Hospital: 1 ☐ Inpatient 2 ☐ EF/Outpatient 3 ☐ 27. Manner of Death 28a. Date of Injury 28b. Time of		me 5 Residence 28d. Describe how	e 6 □Other (Specifinium occurred	v)
ding th. After	tion	1 X Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation M	Work?			
LIVISION for Attending after death. Director: After din by the fune	Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, farm,	actory, office	281. Location (Stree City or Town, S	t and Number or Rura (tate)	l Route Number,
DIVISION OF VIEL INC. To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occur  (Check only one)  Certifying Physician: To the best of my knowledge, death occur  (Check only one)  And manner stated.	urred at the time, date and place, pation, in my opinion, death occurr	and due to the caus red at the time, date	e(s) and manner as s and place, and due to	lated. the cause(s)
To the within To the comp	Me	29b Signature and title of certifier  Aug (1)	29c. License number 3 8 3 3	29d.	Date signed (Month,	Dey, Year)
Q.		30, Name and address of person who co yeled cause of death (Item)23a) (Type, Print)	TOUT MI	D. 21	724	
Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	, , , , ,		-	
Regist	rar	MAY 0 2 2005 Mayor # food	<u> </u>			
<b>DHMH 17 Rev 1/2</b>	001					

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryland			t of Health and e of Death		giene 05	14799
	Physici	an a	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Dav Yea	3. Time of Death
	/Medic		Mitchell Taylor					April	22 200	
	Examin	er	4a. Facility Name (If not institution, give s			4b. City,	Town, or Location of Deat	n	4c. County of De	
			Prince George's F  5. Social Security Number 6. Sex			If Under	Cheverly 1 Year   If Under 24 Hrs	9 Date of Bir		George's  Birthplace (State or Foreign
	Funeral Director			IM 2□F 47	Yrs.	Months	Days Hours Min.	8. Date of Bir	<sup>17</sup> 1957 Wa	Shirngton DC
	riand ow		10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits
	Many F-f sh	tor	MD Prince Ge	orge's Ca	apitol	Heig	hts			1 Yes 2 □ No
	th the	irec	10e. Street and Number		-	10f. Zip			10g. Citizen of What	
	15 wi	aic	623 Drum Ave			20	0743		United Sta	ites
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-1 show eny injury or other treumatic event, It a Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1	1	Vas Deced Yes, spec ☐ Yes 2	lent of Hispanic Origin? (S lify Cuban, Mexican, Puerl 2 No Specify:	pecify Yes or No o Rican, etc.)	14. Race - Ar Black, W Specify: V	
5-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced	ent's Usua	I Occupation	rkina	16b. Kind of Busines	ss/Industry
2	within iene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			k done during most of wo e retired)	9	D	
2	e filed within al Hygiene. I other then "		9 17. Father's Name (First, Middle, Last)		Auto	Mecha		no (Cimt Middle	Private	
Maryland	2 should be fi and Mental H Is marked ot reumatic ever	To Be	Glen H. Taylor						Maiden Sumame) mer	
	and 2 sho saith and I n 27 Is me		19a. Informant's Name/Relationship (Type Michael Taylor / B				(Street and Number or Ru on Rd #26 Vi			, Zip Code)
altimore,	Pages 1 and 2 nent of Health ent: If item 27 I ary or other tre		20a. Method of Disposition 1 □ Burial 2 🖺 Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)		ace of Dispos metery, crem ropoli			Date 3, 2005	20c. Location - City	
Balti	permit. Pages Department of Importent: If it eny injury or o		21. Signature of Funeral Service License		22. Δ 1	Name and	d Address of Facility ler S. Pope ann Ave SE W	Funeral	Home n DC 2002	20
			23a. Part1. Enter the disease, or complic	cations that caused the death						Approximate
N.	Pnysician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	GUNSHOT	WOUN	0	OF ABDO	MEN		Interval Between Onset and Death
	Examiner	L	Sequentially list conditions, b							
, 0,	ficate be executed physician and st the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
68760,	icate b physic s the b	edical	d							
.O. Box 6	death certi e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 1	Ectopic pre Other (spe			23d. Date of c Month	lelivery Day Year
<u>α</u>	The law requires that the de ate has been signed by the a page 2 should be detached f	by	Part II. Other significant conditions con	tributing to death but not resu	lting in the un	derlying ca	ause given in Part I.	23e. Did to		to the cause of death?
Ö	w require been si should b	etec						1		
of Vital Records,	The lay	Completed								
/ita	certific	Be	25. Was case referred to medical examiner?	oonitel: T7				th (Check only o	ne)	
of	Physical this call dir	To	1X Yes 2 No		R/Outpatient				dence 6 Other (Sp	pecify)
n	fing I	lon	1 ☐ Natural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury		Bc. Injury at Work?	SVBTE	now injury occurred  WAS	SHOT
Division	death death stor: / the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hor	t :00 A		1 Yes 2 No		Street and Number or	
Ŏ.	lor A after Direct in by	ertif	4 Homicide determined	building, etc. (Specify)	)	oi, raciory,	, once	City or Tov	vn, State)	
	Hospita 4 hours Funeral ely filled	edical Co	(Check only 2 X Medical Examin	ician: To the best of my knowner: On the basis of examinati	vledge, death ion and/or inve	occurred a	at the time, date and place in my opinion, death occu	, and due to the	VIT AVE, SVI cause(s) and manner date and place, and di	as stated.
	To the h within 2. To the f complet	Med	29b. Signature and title of certifier	and manner stated.			License number		29d. Date signed (Mo	
i i	To To	-	250. Signature and little of dertiner	<b>Y</b>			OCME			
	9		· unex	The second secon	00-) =				April 22,	2005
	) "		30. Name and address of person who con		23a) (Type, P		lll Penn Str	eet Bal	timore. Ma	aryland 21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Pegistrar's Signatu	12 6	ande			The The	
	Registr	ar	MAY 0 2 20	105 Blown 1	1	income.				

			1 - For State Registrar		Marylar			of Hea		Mental H	ygiene Reg. No		14800
	Physici	an	Decedent's Name (First, Middle, I							2. Date of D	eath Da	y Year	3. Time of Death
	/Medic		Quinton	E. 7	Thom	25011				04	2		5 19:36 M
	Examir	ier	4a. Facility Name (If not institution, g	give street and number	er)			Town, or Loc	cation of Dea	th	- 1	. County of Dea	
				land Hus	<del></del>			inten					George
	Funeral		, and the second	.Sex 7. 1√2 M 2 ☐ F	Age (In yrs. 42	last birthday) Yrs.	If Under 1 Months		Under 24 Hrs Hours Min		irth ay, Year)	9. Bi	thplace (State or Foreign ountry)
	Director		579-80-0487 Usual Residence of Decedent		42	113.				Dec 9,	1963	3 Wash	nington DC
	vland ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Mary First	ģ	MD Prince	George's	0x	on Hil	1						12∑Yes 2 No
	r 28e	Director	10e. Street and Number				10f. Zip (	Code			10g. Cit	tizen of What C	ountry?
	h witi	a D	5603 Helmont Pl	ace			20	745			Unit	ed Stai	tes
	deal	Funeral	11. Marital Status	12. Was Decede Armed Force		.S. 13. V	Vas Decede	ent of Hispan	inic Origin? (S	Specify Yes or N to Rican, etc.)	10-	14. Race - Am	
98	ours after death with the Marylan rel', or Items 23e or 28e-f show Examiner must be notified at		1 ☑ Never Married 2 ☐ Married	1 1 Yes 21		1	Yes 2		ipecify:	to nican, etc.)		Black, Whi	
8	72 hours after death with the Maryland ineturel', or Items 23e or 28e-f show dissel Examiner must be notified at	d b	3 Widowed 4 Divorced	Year or Date	s:							Specify: D 1.0	
21215-0036	"net	Completed by	15. Decedent's (Specify only highest of			16a. Deced	lent's Usual kind of work	Occupation done durin	n ng most of wo	rking	16b. K	ind of Business	/Industry
12	within ene. then "	mo	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Unemp		e retirea)					
d 2	filed Hygi ther		17. Father's Name (First, Middle, La	st)		onemp	TOYEU	18.	Mother's Na	me (First, Middle	e Maiden	Sumame	
an	ld be ental ked o	To Be	Samuel Bosfield						Stella			ournamo)	
Maryland	2 should be filed within n and Mental Hygiene. r is marked other then "reumetic event, the Mes	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (	Street and i	Number or R	ural Route Numi		or Town, State.	Zip Code)
	s 1 and 2 should be filed within 72 hours if Health and Mental Hygiene. Item 27 is marked other then "neturel; other treumetic event, the Medical Era		Clifton Thompson	/ Brothe	er					on Hill			
J.	of He of He item		20a. Method of Disposition		1 6	Place of Dispos	sition (Name	e of ner place)	1	Date	20c. Lo	ocation - City or	Town, State
Ē	Pages nent of t ant: If ite		1 ⊈Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec			Linco			y   5-3	-2005	B1ad	lensburg	g MD
Baltimore,	permit. Pages Department of Importent: If it any injury or o	1	21. Sociure of Funeral Service Lic	ensee	~	A <sup>22</sup>	Name and	Address of	Facility	Funeral	Home		
<u> </u>	8288		salona /1	700	N					ashingto			
г			23a. Part . Enter the disease, or co shock, or heart failure. List on	mplications that caus ly one cause on each	ed the death line.	h. Do not ente	er the mode	of dying, su	uch as cardia	c or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Respi	retun	1 fail	we.						Onset and Death
	/Medical Examiner		resulting in death)		as a conseq	ence of):		520					7-
		-	Sequentially list conditions,		onic	obstru	ichiul	Pul	lmona	my Dis	eask	2	
77	ted	Examiner	Sequentially list conditions, if any, Isaumy to immediate cause. Enter Underlying Cause (Disease or injury	(	as a conseq	derico ori,		0	. ,	ny Dis			
	be executed sician and burial-transit	xar	that initiated events resulting in death) Last	cOue to (of	as a consequ	uence of):	Ken	Ga	ulline				
8760	e be e	dical		,		sun							
9	death certificate be executed e attending physician and nd for use as the burial-transit	edic		-		124.00.							
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon			F-4					23d. Date of del	ivery
	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant	at time of di		Ectopic pred Other (spec					Month	Day Year
P.0	at the de I by the stached	hys	9 Unknown										
	The law requires that the site has been signed by th bage 2 should be detache	by	Part II. Other significant conditions	contributing to death	n but not resi	ulting in the un	derlying cau	use given in	Part I.			_	the cause of death?
ord	w requir been s should	ted								1 🗆	Yes 2	□ No 3 □ Pr	obably 4 Unknown
Records,	e law has b	ompleted								24a. Was		24b. Were au	topsy findings available completion of cause of
1990		Con								perfe 1 ☐ Yes	ormed? 2 No	death?	_
Vital	Physicien: T r this certificateral director, pa	Be	25. Was case referred to medical examiner?	Hospital:						ath Check onl			
of	Phys this al dir	2	1 ☐ Yes 2 🔀 No  27. Manner of Death	1 Inpa		ER/Outpatient			Nursing H	lome 5 Res			city)
	fte	lo	1 XNatural 5 ☐ Pending		Day Year)	28b. Time of Injury	М 280	c. Injury at Work? 1  Yes	2 🗆 No	28d. Describe	now injur	y occurred	
Division	Attending r death. sctor: After by the fune	ficat	2 Accident investigati 3 Suicide 6 Could not	be Ope Place of I	Injury - At ho	me larm stre			2 🗆 110	28L Location /	Street an	d Number or Ri	ıral Route Number.
Ρį	or it it	Certification;	4 Homicide determine	building,	etc. (Specify	()	or, radiory,	omoo		City or To	wп, State	)	rar rioute remider,
	Hospitel 14 hours a Funerel ( tely filled	<u>603</u>	29a. Certifier 1 Certifying F	Physician: To the be	st of my kno	wledge, death	occurred at	the time, da	ate and place	, and due to the	cause(s)	and manner as	stated.
	To the Hospitel within 24 hours a To the Funerel I completely filled	edic	(Check only 2 Medical Exa	aminer: On the basis and manner	of examinal	tion and/or inv	estigation, in	n my opinior	n, death occu	irred at the time,	date and	place, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				29c. l	License nun	mber		29d. Dat	e signed (Monti	
-	~		3-3hav	MD. Ph	1.10.		D	5793	37			04/24	1/2005
2	•		30. Name and address of person who						00===		W	Worker to Like	
"			Zirong Vhao , M 31. Date filed (Month, Day, Year)	7503	ourrat	ts Rd	Clinto	on MD	20/35				11
	Sta Registr		MAY 0 2	2005	June 1	to Ap							

			_			State of M	arvlan					-		egible.	1 1
		•	1 - State	e istrar			,			te of E			Reg. No	4000	4801
	Div. del				(First, Middle, La	ist)						2. Date of Month			3. Time of Death
	Physici /Medic			40	Yd 1	ayor						Ann	2		- 11:52 PM
<b>)</b>	Examin		4a. Facilit			e street and number	)	1 1	4b. Cit	, Town, or	Location of Dea	•	40	. County of Deat	
			E Social	Security Nur	Men		vspr	Tal	If Lind	Day er 1 Year	If Under 24 Hr	5   0   0   0   1	Dist	NIT	T
	Funeral Director		215	-an-		10 M 2 F	ge (IN yrs. 24	last birthday) Yrs.	Month		Hours Mir	8. Date of Month,	Birth Day, Year,	1967 9. 81	hplace (State or Foreign untry)
			Usual Re	sidence of E								ipii	10/	TAN T	Jary 141 Ca
	arylar show	_	10a. Stat	θ	10b. County	11	10c. Cit	y, Town or Loc	ation 2	110					10d. Inside City Limits
	he M	ecto	-	et and Numb	N	1			D	411M	VI C		12 0		1 ∰Yes 2 No
	with 1		100. 500		Ynx	RD A	0+1	03	101. 2	ip Code	1012		10g. Ci	tizen of What Co	untry?
	filed within 72 hours after death with the Maryland Hygiene. sther than "neturel", or tems 23a or 28a-f show ent, it e Medicel Examirer must be notified at	Completed by Funeral Director	11. Marit	al Status	10.11	12. Was Decedent	Everja U		as Dec	edent of His	panic Origin? ( , Mexican, Pue	Specify Yes or	No-	14. Race - Ame	rican Indian,
စ္	or Ite	Für	1 ☑⊀	lever Married	d 2 Married	Armed Forces  1 Yes 2 1  If Yes, Give	? No		_			rto Rican, etc.)		Black, White	e, etc.
8	urel',	d by	3 🗆 V	Vidowed 4	Divorced	Year or Dates:			162	2 No	Specify:			Specify:	nct.
<u>.</u>	"nett	lete		(Specify	5. Decedent's E only highest gr	ducation ade completed)		16a. Decede	ent's Us	ual Occupa	tion uring most of we	orking	16b. K	(ind of Business/I	Industry
12	filed withi Hygiene. ther than ent, live M	dmo		ntary/Second		College (1-4or	5+)	1116. 0	. ,	nto,			(	Thines	Inc.
ğ	e filed Il Hyg other	BeC			irst, Middle, Last	)					18. Mother's Na	me (First, Mid	dle, Maider	Sumame)	1
/land	should be nd Mental marked c	ToE	<u> </u>	eny	1ayl	or					Betty	Ann	-Oli	ver	
Mary	C1 c2 c2 c2		19a. Info	rmant's Nan	ne/Relationship	Type, Print)		19b. Mailing	Addre	ss (Street a	nd Number or F	Rural Route Nu	mber, City	or Town, State, 2	(ip Code) 21223
	1 and Health em 27 ther tr		000 1404	eins.	Johns	DV 201	120h E	Place of Dispos	6	170	deric	Date	C, E	SOLHTANOS	e Maryland
ltimore,	Pages nent of Hent of Hent of Hent of Hent of Hent or ot		1 🗆		Cremation 3	Removal from State		cemetery, crem	atory of	other place	2	20/65	20c. L	ocation - City or	lowry, State
틆	permit. Pag Department Importent: I eny fnjury o				Other (Special Service Lies		Mile	170 L	Name	and Address	of Facility D	20105	La	TOVEN	112 Maylan
Ba	permi Depar Impor eny ir			Ken	m 54	In Yen		30	12	Fred	exicate	120	改门	al non	NO 502 9
	_		23a. Pai	t1. Enter the	disease, or con	one cause on each	d the deat	h. Do not ente	r the mo	ode of dying	, such as cardia	ac or respirator	y arrest,	The state of	Approximate Interval Between
Ļ	Physician		Immedia	te Cause (F or condition		A c. ta	Q.	1 - 1 - 1	5		+	0 1	3 000		Onset and Death
	/Medical Examiner		resulting	in death)	-	Due to (or as	s a conseq	juence of):	wn	<u>ow</u>	1 den	Jynd	NUTTE		12 hours
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	ted nsit	Examiner	Cause (L	ially list cond ading to imm Enter Underly Disease or in	rediate ring jury	Due to (or as	s a conseq	uence or):							
,	execunand and all-tra	Exar	that initia	ited events in death) La		C. Due to (or as	s a conseq	uence of):							
8760,	ficate be executed physician and is the burial-transit	call			l	d									
9	rtifical ng ph as th		IF FEMA	15.		=//									
Вох	ath ce ttendii	an/I	23b. Wa	s decedent p ne past 12 m		23c. If yes, outcome 1 ☐ Live birth			Ectopic	pregnancy				23d. Date of deli	,
O.	he dea	Physician/Med	1 🗆	Yes 2 🗆		4□ Pregnant a 9□ Unknown	at time of d	leath 5	Other (	specify)			-	Month	Day Year
P.0.	es that the death certific igned by the attending p be detached for use as	Ph			ant conditions	contributing to death	but not res	ulting in the un	dertvina	cause give	n in Part I.	23e. D	id tobacco	use contribute to	the cause of death?
Records,	urres sign d be	d by						•	, ,	3					bably 4 Uaknown
OS	w require been signature should b	Completed										24a. W	fas an	24b. Were aut	topsy findings available
Be	The la te has age 2	omp										at pe	utopsy erformed?	prior to c death?	ompletion of cause of
ta	ien: rtilica stor, p	0			d to medical						26. Place of De		s 2,⊡rNo lyone)	1 ☐ Yes	2 0 00
Division of Vital	hysic his ce I direc	To B		niner? Yes 2 □uN	6	Hospital: 1 🖂 Unpati	ient 2 🗆	ER/Outpatient	3 🗆 🛭	Otho	~			6 ☐Other (Spec	ify)
o u	ing Pl			er of Death	5 Pending	28a. Date of Inj (Month, Da	ury a <i>y Year)</i>	28b. Time of Injury		28c. Injury Work		28d. Descrit	oe how inju	ry occurred	
Sio	ttendi death. tor: A	Certification:	2 🗆 /	Accident Suicide	investigation		* AA I		М		es 2 No		10.		
$\leq$	atter of Direction by	ertif		Homicide	determined	28e. Place of In building, e	tc. (Specif	y)	et, facto	ry, office		City or	n (Street al Town, State	nd Number or Rui e)	ral Route Number,
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit		29a. Cer	tifier i	Certifying Pi	hysician: To the best	t of my kno	owledge, death	occurre	d at the time	e, date and place	e, and due to t	he cause(s	) and manner as	stated.
	ne Ho n 24 h ne Fu oletely	Medical	(Ch	eck only 2	☐ Medical Exa	miner: On the basis of and manner s	or examina	ation and/or inve	stigatio	n, in my opi	inion, death occ	urred at the tin	ne, date an	d place, and due	to the cause(s)
	To the To the Comp	Ž	29b. Sigr	nature and ti	tle of certifier	harra	Q P			9c. License				ite signed (Month	
	d		•	K		7	`				8946			1,27,	
1	7,					completed cause of		n 23a) (Type, P	rint)					PARKWAS	1
	Sta	to	31. Date	filed (Manu)	Day Near)	AR A G HA VA		ature _		BA	LTIMO	RE, A	10	21218	
	Regist			MAY	O'.2°200!	32. Regist	K	house							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1745 P WINFALD 2005 /Medical Facility Name (If not institution, give street and number) 4b. City, Tout, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2 F Days Months 217.18.0732 VIRGINIA Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If them 27 is marked other than "natural; or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at DATTIMORE Completed by Funeral Director MD 1 Yes 2 No 10g. Citizen of What Country? U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. of Health and Mental Hygiene.
item 27 is marked other than "natural", or item
other traumatic event, the Wedical Examinar. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) COOK 17. Father's Name (First, Middle, Last) Be NANCU 19b. Mailing Address (Street and Number or Rural Route Number, City or To ASHLAR NIECE 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. GARKISON TOKEST <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee BACTIMORE, MARVIAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ADBNOCORCINONS **Physician** disease or condition resulting in death) 12 MONTH /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funaral Director: After this certificate has been signed by the attending physician and nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Completed by Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes ≥ No Other: 2 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 □Other (Specify) 3□ DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who con

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

3333 NOTH

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corpuent

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death **Physician** Month 8-45A M 25 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner **Funeral** 9. Birthplace (State or Foreign Months Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. shir: If item 27 is marked other than "natural; or itams 23a or 28a-1 ehow 10a. State 10b. County 10c. City, Town or Location itam 27 is marked other than "natural", or Itams 23a or 28a-1 ehow other traumatic event, the Medical Event at must be redified at 10d. Inside City Limits Be Completed by Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3€ Widowed 4 □ Divorced rear or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Busines (0-12) College (1-4or 5+) 's Name (First, Middle, Last, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nod of Disposition Burial 2 Cremation ŏ 3 Remova Department of Importent: If any injury or once. Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 0,0 Due to (or as a consequence /Medical of): Examiner Scler Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy į in the past 12 months?
1 Yes 2 No Month Year Dav 5 Other (specify) the a detached 9 Unknown 9 🗆 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pe 2 No 3 Probably 4 Unknown funeral director, page 2 should Medical Certification; To Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 Yes 2 PNo Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No the f 2 Accident Director: 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide within 24 hours a Hospitel 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To tha ! 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month

501

Who completed cause of death (Item 23a) (Type, Print)

2005

gistrar's Signature

			1 - For State Registrar	State of Marylan		rtment of F			giene	105	14804
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)     William     4a. Facility Name (If not institution, give si	treet and number)	Ilis	Sr, 4b. City, Town, o	r Location of Death	2. Date of De Month	ath Day	Year 2005 inty of Death	3. Time of Death
	Funeral Director		5. Social Security Number 6. Sex	and HOSP:  7. Age (In yrs.  60	fal last birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	Cour	lace (State or Foreign
	the Maryland 28a-f show	rector	10a. State 10b. County Virginia Fairfa)  10e. Street and Number		y, Town or Loc -all5	Churce 10f. Zip Code	h		10a. Citizen	of What Coun	0d. Inside City Limits 1 □ Yes 2 ☑ No
99	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23e or 28a-f show any injury or other traumatic event, Ite Medical Examinat must be motified at once.	/ Funeral Directo	2911 Charing C.  11. Marital Status 1  1 □ Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces?  1		220	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. F	USA Pace - Americ Black, White,	ean Indian,
21215-0036	filed within 72 hours Hygiene Sther then "neturel", ent, Iho M. cical Exa	Completed by	3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates:	16a. Decede	ent's Usual Occup	ation during most of work	king		f Business/Ind	dustry
Maryland 2	should be filed and Mental Hygi is marked other aumatic event, I	To Be Co	17. Father's Name (First, Middle, Last)  CWIS Wi  19a. Informant's Name/Relationship (Typ.	OPE, Print)	19b. Mailing	Address (Street	18. Mother's Nam	inita	RI	isse	(Code)
altimore, Ma	Pages 1 and 2 and 10 tent of Health arent if item 27 is iry or other trau		Sandra Y Willis  20a. Method of Disposition 1 Burial 2 Scremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	29// Clace of Dispos emetery, crem	haring C.	ross Road		15 Chur 20c. Locatio	6 (4)	2042
Balti	permit. Pag Department Important: i any injury o		21. Signature of Funeral Service License  Robert B  23a. Part1. Enter the disease, or complice shock, or heart failure. List only on.	Balun de cations that caused the death	22. Chi	Name and Address	al Service 2		rlington le		Approximate Interval Between
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq ANEMI/	uence of):	240515	5				Onset and Death
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.O. Box 6	the death certify the attending ched for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3 □	Ectopic pregnancy Other (specify)				Date of delive Month	ory Day Year
٥	w requires that been signed by should be deta	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the und	derlying cause giv	en in Part I.				ne cause of death?
tal Rec	The larate has	e Completed	25. Was case referred to medical				26. Place of Deat	1 Tes	osy rmed? 2 No	prior to con death?	psy findings available inpletion of cause of
Division of Vital Records,	ding Phys .r After this funeral dii	ation: To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injun World	er. 4 □ Nursing Ho		dence 6 🗆		")
Divis	lospital or Attend I hours after death unerel Director: sly filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	y)			City or Tox	vn, State)		l Route Number,
	he kin 24	Medical	29a. Certifier (Check only one)  2 Medical Examin  29b. Signature and title of certifier	ician: To the best of my kno ter: On the basis of examina and manner stated.	wledge, death tion and/or inve	occurred at the tin estigation, in my o	pinion, death occur	red at the time,	date and plac	manner as st ce, and due to ned (Month, I	the cause(s)
)	or with		b / diacous	omo			18158		TORIL	_	2005
か)	)		30. Name and address of person who cor	19) OX.ON	HILL R	JAD ST	E SOO,	Oxon	1+TLL	MD	20745
	Sta Registr		31. Date filed (Month, Pay, Yex) 2 2	32. Registrar's Signa	ture y	back					

	- State Certificate of Death Registrar	200	Property of the same case case
		g. No.	5 14805
an	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  April 26	Day Y	3. Time of Death
al	April 20		08:17 a.M
er			
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth		9. Birthplace (State or Foreign
			Maryland
			10d. Inside City Limits
ō			1 ☐ Yes 2/QNo
rect		g. Citizen of Wh	nat Country?
o ie	26 Lombardy Drive 21222	Unite	d States
ner		14. Race -	- American Indian, White, etc.
	1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify:		White
	3 Wildowed 4 Divorced Year or Dates:		
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mo	Elementary/Secondary (0-12) College (1-4or 5+)	Paradi	se Motors
d)			
	Frederick G. Wenker, Sr. Do	lores L	. Manuel
i			
	20a. Method of Disposition    20b. Place of Disposition (Name of cemetery, crematory or other place)   2	0c. Location - C	ity or Town, State
		5 Dund	alk, Maryland
	Duda-Ruck Funeral Home of		
			Approximate
	shock, or heart failure. List only one cause on each line.		Interval Between Onset and Death
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ner	Sequentially list conditions, if any, leading to humodate cause. Enter Underfying		
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y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did toba	acco use contrib	oute to the cause of death?
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piet		24b. W	ere autopsy findings available for to completion of cause of
E O	y perform	ied? de	ath? QYes 2□ No
	examiner?	)	
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ficat	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Str.	eet and Number	r or Rural Route Number,
ertii	4 ☐ Homicide building, etc. (Specify) City or Town,	, State)	
	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ca	use(s) and man	ner as stated.
edic	(Check only one)  2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, da and manner stated.	te and place, an	nd due to the cause(s)
ž		d. Date signed	(Month, Day, Year)
1	HOUR - LOUGH IS OCHE	April 27	2005
		TOTAL CI	4 4000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Para Cia Aca, ya Pallak w 111 Penn Street Balt	•	,
	o Be Completed by Physician/Medical Examiner	#26 Lombardy Drive  \$. Social Security Number   10. Security Number   10. Security Number   10. Security Number   10. Security Number   10. Security Number   10. Security Number   10. Security Number   10. Security Number   10. State	#26 Lombardy Drive  100 June 1

				State of Maryland  1- State Registrar	/ Department of Health and I  Certificate of Death	-	ne 2005 ILOGG
		Physici /Medi		Decedent's Name (First, Middle, Last)     ESLEY MCKINLEY WHITT		2. Date of Death	Day, 2005 2 43 0 M
		Examir	ner	4a. Facility Name (If not institution give street and number)  Maryland General Hisp	tal Eastimore Cr	ty	4c. County of Death N/A
		Funeral Director		5. Social Sectority Number 6. Sex 7. Age (In yrs. last 228–16–6942 1 \(\frac{1}{N}\)M 2 \(\sigma\)F 83	t birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth  (Month, Day 72)	ar)  9. Birthplace (State or Foreign NORTH CAROLINA
		Maryland -1 show	tor	10a. State 10b. County 10c. City, 7	Fown or Location		10d. Inside City Limits 1 □ Yes 2√2 No
		death with the Maryland ms 23a or 28a-f show	ai Direc	10e. Street and Number 8 BURR OAK	10f. Zip Code 21133	10g.	Citizen of What Country?
-1	920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at Once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Widowed 4 □ Divorced  1 □ Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes, Give  Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: BLACK
1:4	Maryland 21215-0036	within 72 hou ane. Ihan "nature ne Wedical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)  CRANE OPERATOR	king 16b.	. Kind of Business/Industry
111	land 2	uld be filed tental Hygierked other tic event, it	To Be Co	17. Father's Name (First, Middle, Last) JOHN ADAMS WHITT	18. Mother's Nan	ne (First, Middle, Maid	den Sumame)
ley		and 2 shousalth and Market 127 is mailer traumailer tra		19a. Informant's Name/Relationship (Type, Print) DONNA WHITE (DAUGHTER)	19b. Mailing Address (Street and Number or Ru 8 BURR OAK RANDALLS		
13	Baltimore,	Pages 1 Iment of He tant: If Iten		1 🔀 Burial 2 □ Cremation 3 □ Removal from State GARR	e of Disposition (Name of etery, crematory or other place) ISON FOREST VETERANS	5-4-2005 0	
	Bal	Depar Depar Impor any in		Janath Offer		ST. BALTIM	ORE, MARYLAND 21217
		Physician /Medical		23a. Part1. English the disease, or complications that caused the death. I shock, of reart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	incer		Approximate Interval Between Onset and Death
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	II Reco		Completed	Chronic Anemia		24a. Was an autopsy performed 1 Yes 22	
	Division of Vital Records,	ng Phy fter this	Certification: To Be	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year)	Othor	th Check on one ome 5 Residence 28d. Describe how in	
	Divis	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)		City or Town, Sta	
		o the Hosp ithin 24 ho the Fune impletely fi	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.  29b. Signature and title of certifier	dge, death occurred at the time, date and place, and/or investigation, in my opinion, death occur 29c. License number	rred at the time, date a	(s) and manner as stated.  Ind place, and due to the cause(s)  Date signed (Month, Day, Year)
	•	¥ }		It Long	89528	4	4/28/05
	10	) '\ Sta	te	30. Name and address of person who comfleted cause of death (Item 23)  1. Date filed Month, Day, Year)  32. Registrar's Signature	10 Maryland G	reneral	Hospital
		Registr		MAY U I 2005	Source		

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment			ind Me	ental H	ygien Reg. N	2000	14807
	Dhuaisi		1. Decedent's Name (First, Middle, Last,	)						2. Date of D	eath		3. Time of Death
	Physici /Medio		NORELLA LOUISE TH	OMAS ALBE	NOTTIS					Month April	18	2005	2:03 A M
F	Examir	ner	4a. Facility Name (If not institution, give			4b. City, 1	Town, or	Location o	f Death	_	4	c. County of Dea	ith
			1024 Dorset Drive 5. Social Security Number 6. Sec			Walde If Under		If Under 2	24 Hen			Charles	
	Funeral Director			]м 21 <u>Х</u> ДF	e (In yrs. last birthday, Yrs.	Months	Days	Hours	Min.	B. Date of B (Month, D	ay, Yea		thplace (State or Foreign ountry)
			Usual Residence of Decedent		94				1	VOV 16	19.	lo Ivri	ginia
	nylan show		10a. State 10b. County		10c. City, Town or L	ocation							10d. Inside City Limits
	8a-1 s	Director	Maryland Charles		Waldorf						,		1 X Yes 2 □ No
	with th	Dir	10e. Street and Number 1024 Dorset Drive			10f. Zip						itizen of What C	ountry?
	eath	eral	11. Marital Status	12. Was Decedent	Ever in II S 12		0602	anania Oria	in2 /Case	ifu Van as N		JSA 14. Race - Am	nices Indian
10	ours after death with the Marylar ral', or itams 23a or 28a-f show Experiment out the monthled at	Funeral	1 Never Married 2 Married	Armed Forces?  1 Tyes 2-7	No	Was Decede If Yes, speci		n, Mexican,	, Puerto R	ican, etc.)	.0-	Black, Whi	
93		by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 Yes 2	No	Specify:				Specify:	White
21215-0036	s within 72 hours plane. r than "natural", ir e Medic. Ext	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual	k done d	uring most	of working	<i>q</i>	16b.	Kind of Business	/Industry
12	within ene.	ldm	Elementary/Secondary (0-12)	College (1-4or 5	5+)	DO NOT us	,		O.E.			Т	
9	Hyg Hyg tha		12 17. Father's Name (First, Middle, Last)			laims	Supe			First Middle	e Maide	INSU	rance
Maryland	should be id Mental marked o	To Be	John Thomas									,	
ary	2 should and Men is marke aumatic	۱	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address	(Street a			rker Route Numi		or Town, State,	Zip Code)
	s 1 and 2 should f Health and Men itam 27 is marke other traumatic		Ellenda Shaw (Gran	ddaughter	) 1024	Dorse	t Di	rive I	Waldo	rf. M	D 20	602	
ore	ges 1 at 1 of He If itam or oth		20a. Method of Disposition 1 ➡Buria/ 2 ☐ Cremation 3 ☐ F	lemoval from State	20b. Place of Dispo cemetery, cre	osition (Nam matory or oti	ne of ther place		Da	te	20c.	Location · City or	Town, State
Ë	Pages ment of ant: If it		'4 Dorration 5 Other (Specify)	amoval itotii State	Cedar Buf	f Cem	١.	4	1-21-0	05		Annapo	lis, MO
Baltimore,	permit. Pag Department Important: any injury o		21. Signatur of Filtheral 6. (ce Licens	MO01	73	2. Name and	d Address	s of Facility	Ebe	rwein	Fun	eral Sei	
	20 2 8 Q		23a Part 1. Enter the disease, or compl	wer	4.	433 Wh	<u>nite</u>	Pls.	La.	White	P1s	., MD 20	0695
6			23a Part1. Enter the disease, or complete hock, or heart failure. List only or Immediate Cause (Final	ne cau on each lir	ne.	ter the mode	or aying	, such as o	cardiac or	respiratory a	arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as	nonary	7	LAC	AU					
ķ.	Examiner			Morto	consequence of:	n A	INI	1m	9, 4	PPLIS	M		
	F -	je.	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	o.	a consequence of):		V10	~	1.4	40.0	0.1		
	cuted nd transi	Examine	that initiated events	·									
90,	be executed sician and burial-transit		resulting in death) Last	Due to (or as	a consequence of):								
8760,	cate be ex physician the burial	dlcal		J									
9	the death certificate y the attending phys iched for use as the	lan/Me	IF FEMALE:	3c. If yes, outcome	of pregnancy		-						
Вох	atten for us	clan	in the past 12 months?		2 Fetal death 3	Ectopic pre						23d. Date of de Month	livery Day Year
o.	that the de ed by the detached	Physica	1 Yes 2 No 9 Unknown	9□ Unknown	tune of death 35	2 Ottler (spe	,ciry)						
Δ.	The law requires that tte has been signed b age 2 should be deta	by Pł	Part II. Other significant conditions con	tributing to death b	ut not resulting in the u	nderlying ca	use give	n in Part I.		23e. Did	tobacco	use contribute to	the cause of death?
Records,	v requires been sign should be		Hypertena	har H	cart D	sea	Se	) 		10	Yes 2	XNo 3□P	obably 4 []Unknown
000	e law requ has been je 2 shoul	plet								24a. Was		24b. Were au	utopsy findings available
æ		Completed								auto perf	ormed? 2X N	death?	completion of cause of 2 ☐ No
Vital	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					26. Place	of Death	Check onl			
of	Physi this c	ပ္	1 ☐ Yes 2 💢 No	lospital: 1  Inpatie				4 🗀 Nui:				6 □Other (Spe	cify)
UC	ding f	ertification;	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	ry 28b. Time o y Year) Injury	f 28 M	Bc. Injury Work	?		d. Describe	how inju	ary occurred	
Division	Attsnding r death. actor: After by the funer	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	ury - At home, farm, str			es 2⊡N		f Location (	(Street a	nd Number or Ri	ural Route Number,
Ö	after Dira d in b	erti	4  Homicide determined	building, etc	c. (Specify)	oot, ractory,	omoo			City or To			na rioute rumber,
	To the Hospital or Attanding within 24 hours after death.  To the Funaral Diractor: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Physical Check only 21 Medical Examin	sicien: To the best of	of my knowledge, death examination and/or in	n occurred a	it the time	e, date and	place, an	d due to the	cause(s	s) and manner as	stated.
	the hin 24	Medi	one	and manner sta	ated.				7 00001160	at the time,			
	To To com	-	29b. Signature and title of certifier	to			License	125	07		29d. Da	ate signed (Mont	- 1
1				γ,			00	ハイン	8/		7	18-	(1)
	B		30. Name and address of person who co	•		,	_						
	Sta	te	G. Shankar Rath, 31. Date filed (Month, Day, Year)	M . D . /-C 32. Regis	Post Office ar's Signature	e Rd.	Ceni	na Me	dical	_Ct	Walc	lorf, MD	20602
	Registr		APR 1 9	2005	mercas Do	Gore							

State of Maryland / Department of Health and Mental Hygiene

									Cert	tifica	te of	Death			Reg. No	.20	05	14808
	Dhuciniar		ecedent's Name	(First, Middle	e, Last)									2. Dete of De Month	ath Da	ıy	Year	3. Time of Death
	Physiciar /Medica		Pansy	L.	Вее	ebe			_					04	16	20	05	5:00am
	Examine	40 E	acility Name (If	not institution	n, give str	eet and nu	ımber)					4b. City, To	wn, or Lo	cation of Deat	1 40	. County	of Deeth	
		7	420 Po	comok	e Ri	ver	Rd.					Pocon			5	Some	rset	
	Funeral	5. Sc	cial Security No	ımber	6. Sex	2×F	7. Age (In	-	-	If Unde	r 1 Year Days		24 Hrs. Min.	8. Date of Bir (Month, Da	v. Year	)	9. Birthpl	ace (State or Foreign
	Director		0 - 34 - 6		1	2E3 F	10	0	Yrs.					5 23	15	904	Virg	ínia
	yland	10a.	State	10b. County			100	. City, Tow	n or Loc	ation	_						10	Od. Inside City Limits
	Mar Mar	5	VA	Accom	ack			Chin	cot	eaq	ue							1 DYes 2 □ No
	the rate	10e.	Street end Nurr	ber							p Code				10g. Ci	tizen of V	/hat Coun	try?
	fier death with the Ma r items 23a or 28a-fe riner mast be notified	3	814 Ma	in St	root	_				2	333	6			US	SA		
	me 2	11. N	farital Status	111 00		. Was Dec	edent Ever	in U,S.	13. W	as Dece	dent of I	Hispanic Ori	gin? (Spe	cify Yes or No		14. Race	- America	
Maryland 21215-0020	w 0 E .		☐ Never Marrie			Armed For 1 ☐ Yes If Yes, Gir Year or D	2∭∑No ive					san', Mexicar Specify:		tican, etc.)		Specify	k, White, o	
Ş	should be filed within 72 hours nd Mentel Hygiene. marked other than "naturel", urnatic event, the Medical Exa	3	••	15. Decedent				16a	Decede	ent's Usi	al Occu	pation			16b. H	(ind of Bu	siness/Ind	
15	ed within 72 horygiene. Nor then "neture It, the Medical	į		fy only highes	st grade c	ompleted)			(Give k	ind of w	ork done ise retire	during mos	t of workir	ng				•
212	the the	E E	ementary/Secor	ndary (0-12)		College (	(1-4or 5+)	Ì	Но	use	wif	e			Do	omes	tic	
P	Hyge	17. F	ather's Name (	First, Middle,	Last)			1				T	r's Name	(First, Middle	Maider	Sumam	e)	
an	d be fill and the control of the con	Ď.	James	Berr	37							Est	her	Barr	nes			
<u> </u>	Hould Men		Informant's Na		-	Print)		19b	. Mailing	Addres	s (Stree			I Route Numb		or Town.	State. Zip	Code)
Z	d2 s th an 7 ie treu						_		_									D 21851
	1 en Heal em 2 ther	20a	ris B.	osition	Lams	/dau	ghter <sub>20</sub>	b. Place o cemete		_	_		= 1	Date			City or To	
و	T it of or o		1 M Burial 2 □	Cremation		noval from	State							10 0			•	
ŧ	the tant	-	Donation					Down:						-18-0				VA
Baltimore,	Departiment important	21.3	Signature of Fur	meral Service	Licensee	1.7	Port											al Home
		23a	Part 1/ Enter th shock, or hear	e disease, or	complica	tions that	caused the	death. Do	not enter	r the mo	de of dyi	ng, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between
1	Physician		SHOER, OF HEAT	t tanure. List	Only One	Cause on e	each ine.										}	Onset and Death
ز	/Medical	Imm	ediate Cause (	inal		1	1/-	1	1	-							!	1
	Examiner	resu	ase or condition Iting in death)		θ	512	Dua	to for as a	consequi	ence of	ı-							year
		<u> </u>				M	/	10 (01 43 4	/	4		5	,	rome			1	math
	physician and sthe burial-transit		and the line and	-diate	b		Due	to (or as a	CORSEGU	ence of		7	7 10	one				100011
ď,	n an ial-tr	if en	uentially list cor y, leeding to im ie. Enter Under se (Disease or i	mediate			540	10 (01 45 4	00/10040	0,100 01	•							
68760,	sicia bur		se (Disease or i	njury	C		Due	lo (or as e	concodu	000000								
.89	ng physicie as the bu	resu	lting in death) L	ast			Due	io (oi as e c	consequ	ence on	•						1	
	certi			1	d												-	
Вох	of the death cerd by the ettendir eteched for use	5												l not Did				4
P.O.	the d	Parti	I. Other signifi	cant conditio	ons contri	buting to d	leath but no	resulting ii	n the und	derlying	cause gr	ven in Pert I						the cause of death?
	es thet the death ce igned by the ettendi be deteched for us													10	Yes 2	2 ONO	3   Prob	ably 4 Unknown
of Vital Records,	The lew requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be deteched for use as the burial-transit contractions and the burial physician in the page 2 should be deteched for use as the purifications.	3												24a. Was	an auto	psy	ava	re autopsy findings ilable prior to npletion of cause
e C	The lew requin	<u> </u>			-												of c	seath?
=		5												10	Yus 2	XNo	1[	Yes 2□ No
/ita	certificate rector, pag	25. V	Vas case referr	ed to medical	-								of Death	(Check only o	one)		Oas	sighter's
2	Physician: rthis certific ral director,	2 1	☐ Yes 2	No			Inpatient		utpatient		UA							, residence
0	ng Pl		enner of Death	5 Pendin	ng	28e. Dete (Mon	of Injury oth, Dey Yea	28b.	Time of Injury		28c. Inju Wo	ry et rk?	2	8d. Describe	how inju	iry occurr	ed	
0	Attending or death.	2	Accident	investig	getion					М	1	]Yes 2□	20					
Division	tal or Attanding P rs efter death. al Director: After t led in by the funera		B ☐ Suicide B ☐ Homicide	6 Could in determ	ined	28e. Plece build	e of Injury	At home, fa	ırm, stre	et, facto	y, office		2	8f. Location ( City or To	Street a. wn, Stat	nd Numbi e)	er or Rura	Route Number,
	s effer s effer ed in	5																
	To the Hospital or Attanding Phywithin 24 hours effer death. To the Funeral Director: After thi completely filled in by the funeral Macdines Cerettland.	29a.	Certifier (Check only one)			: On the b								nd due to the d at the time,				
	of the of the omple	-	Signature and	itle of certifie	5/		_			29	c. Licen	se number			29d. Da	ate signed	(Month, E	Day, Year)
	H 3 F 0		6	2/	/_			M. J	,		02	0690			10	ril	18	8 2005
	/ wal	-	- //					// 0=	CT.			10			9			
	2 land		lame and addre	_ /			se of deeth	(Item 23a)	(Type, P	rint)		11 5	*	501.56	· ~	_ /	ND	
		21 5	Date filed (Mont				Registrar's S	Signature	-					/ - 72	-	21_		
	State Registrar		ato mod (morn		9 20	05	Gas La	. 4	. 4	has	2							

			S 1 - For State Registrar	tate of Maryland / Depa	rtment of Health and M tificate of Death	-	ne 2005	14809
>	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)     Jack T. Brill  4a. Facility Name (If not institution, give street)	et and number)	4b. City, Town, or Location of Death		Day Year 5, 2005 4c. County of Death	3. Time of Death 8:35 P M
	Funeral Director		9828 Riverton Road  5. Social Security Number  143-24-7445  Usuel Residence of Decedent	7. Age (In yrs. last birthday) 2 F 74 Yrs.	Mardela Springs  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye July 19, 1	Wicomico 9. Birthple Count 930 New J	ecs (State or Foreign ry) ersey
	the Maryland 28a-f show	Director	10a. State 10b. County MD Wicomico  10e. Street and Number	10c. City, Town or Loc Mardela		10g	Citizen of What Count	od. Inside City Limits 1 ☐ Yes 2 🛣 No
36	hin 72 hours after death with the Maryland b. Madical Examina 23s or 28s-f show Madical Examina must be notified at	by Funeral Di	1 Never Married 2 Marned	1 □ Yes 217 No	21837  Vas Decedent of Hispanic Origin? (SpeYes, specify Cuban, Mexican, Puerto  ☐ Yes 2 ☑ No Specify:	τ	J. S. A.  14. Race - America Black, White, e	an Indian,
Maryland 21215-0036	within 72 ene. then "na	Completed t	15. Decedent's Educati (Specify only highest grade co	on mpleted) 16a. Deced (Give life. L	ent's Usual Occupation kind of work done during most of worki DO NOT use retired) dworker	ing	o. Kind of Business/Ind	
ryland 2	Mental Mental arked c	To Be C	17. Father's Name (First, Middle, Last) William Brill  19a. Informant's Name/Relationship (Type,	Print) 19b. Mailin		izabeth Do	bwd	Code)
	ges 1 and 2 t of Health a if Item 27 is or other train		Emma M. Brill (will	fe) 9820 20b. Place of Disposementary, crem	8 Riverton Road sition (Name of latory or other place)	Mardela S	Springs, MI c. Location - City or Tov	21837 wn, State
Baltimore,	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Licensee	Jewell 1		Delmar, l		
	Tate be executed with a price and was and was and was transit to but a price and the purial transit.	cal Examiner	23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of limediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ons that caused the death. Do not enter ause on each line.  Due to (or as a consequence of):  Due to (or as a consequence of):	Suctive Julmona	Sylva 28 ylva Tha	trong	Approximate Interval Between Onset and Death
.O. Box 68	that the death certificate bed by the attending physic detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy		23d. Date of deliver Month	ry Day Year
ords, P.	w requires that been signed by should be deta	Completed by Ph	Part II. Other significant conditions contrib	outing to death but not resulting in the un	nderlying cause given in Part I.	1 ☐ Yes	/	ably 4 □Unknown
Vital Records,	sicien: The law certificate has t rector, page 2 s	Be	25. Was case referred to medical examiner?  1 □ Yes 2 XNo	Ayrey D	Other	24a. Was an autopsy performed 1 Yes 2 X	prior to com death? No 1 ☐ Yes	
Division of	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	Certification: To	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury Injury  28e. Place of Injury - At home, farm, strebuilding, etc. (Specify)	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how i	t and Number or Rural	
	the Hospital in 24 hours of the Funeral pletely filled	Medical Co	(Check only Z Medical Exeminer one)	an: To the best of my knowledge, death : On the basis of examination and/or inv and manner stated.	restigation, in my opinion, death occurr	red at the time, date	and place, and due to	the cause(s)
	To con	2	29b. Signature and title of certifier  30. Name and address of person who comp	leted cause of death (Item 23a) (Type	29c. License number	42 0	Date signed (Month, D	0 0 5.
	SI	ate	31. Date filed (Month, Day, Year)	MLD, 106 P	PineBluff Rd.	#12 ;	Salisbury	MD.

			1 - For State Registrar	State of	Maryland	d / Depa		t of He	ealth a				005	14810
	Physici /Medic		1. Decedent's Name (First, Middle, Linda Lee BELL	Last)							2. Date of Death Month pril 20	Day 20	Year 05	3. Time of Death 3:45 p. M
	Examin		4a. Facility Name (If not institution, s  Homewood at Wil  5. Social Security Number 6	liamspor	t			/illi	Location of amspo	ort		4c. Co	unty of Death ashing	ton
	Funeral Director		219-44-2814 Usual Residence of Decedent	.Sex 7 1 ☐ M 2 ② X F	7. Age (In yrs. la 59	Yrs.	Months	Days	Hours	Min.	Date of Birth (Month, Day, Jan. 29	Year) , 194	46 Vi	nplace (State or Foreign untry) rginia
	he Marylen 8e-f ehow	ector		ngton	10c. City	Hager	stown							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with t	I D	10e. Street and Number 16931 Alcott R	load			10f. Zip		740		16	og. Citizen US	ı of What Coι Δ	untry?
980	be filed within 72 hours after death with the Marylend ital Hyglene id other than "naturel", or items 23a or 28e-f ehow event. The Medical Exart in at must be incitified at	by Funeral Director	11. Marital Status  1 Never Married 28 Married 3 Widowed 4 Divorced	12. Was Deced	ces? 2 ⊠ No		Was Deced f Yes, spec			in? (Spec Puerto Ri	fy Yes or No- can, etc.)	14.	Race - Amer Black, White	
215-0	within 72 ho ene. than "natur ne wedical I	Completed	15. Decedent's (Specify only highest of the secondary (0-12)	completed) College (1-	4or 5+)		kind of wor DO NOT us	rk done di e retired)	uring most	of working	7		of Business/I	•
Maryland 21215-0036	d be filed within antal Hygiene.	To Be Cor	12 17. Father's Name (First, Middle, La Albert Pfeiffe	-		pro	of re		18. Mother		First, Middle, A			company
ary	2 should be f and Mental I Is marked of eumatic ever	ř	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a			Route Number,	City or To	own, State, Z	ip Code)
	2 = 2 = 2		Robert J. Bell	- husband										nd 21740
Jore			20a. Method of Disposition  1X□ Burial 2 □ Cremation 3			ace of Dispo emetery, cren ar Law				Da			ion - City or 1	
Baltimore,	permit. Pege Depertment of Important: If any injury or		* 4 □ Donation 5 □ Other (Spe 21. Signature of Furreral Service Lice		enne	722	. Name an	d Address	s of Facility	111	NNICH F Hagerst	UNERA	AL HOM	
	Prysician /Medical Examiner	ılner	23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a Due to (d	or as a consequence as a consequence or a consequence or a con	M/G	er the mode	e of dying	, such as c	eardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death
O. Box 68760,	thet the deeth certificate be executed od by the attending physician and detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	rth 2 ☐ Fetal ant at time of de	ncy death 3	Ectopic pre					23d	. Date of delin	very Day Year
rds, P.	Se un eg	by	Part II. Other significant conditions	s contributing to de	ath but not resu	ilting in the u	nderlying ca	ause give	n in Part I.		23e. Did tob	-		the cause of death?
Vital Records,	The law ate has b page 2 sl	Completed	Dichola M	ello	Wet						24a. Was ar autopsy perform 1 Yes 2	/	4b. Were aut prior to c death?	topsy findings available completion of cause of
<u>K</u>	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:				Other			Check only one			
ot	ding h. After fune	-	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigal	28a. Date o		ER/Outpatien 28b. Time of Injury		Bc. Injury Work	- A I HOI	- 28	5 ☐ Reside d. Describe ho			ify)
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}	with To I	2	29b. Signature and title of certifier	10	>			DE		06			igned (Month	. Day, Year) 2005
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year William Robert Borum 1:00PM<sup>M</sup> Apri] /Medical 17 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County

9. Birthplace (State or Foreign Country) 16808 Petmar Circle
5. Social Security Number 6. Sex Hagerstown
If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. **№**□ M 2□ F Director 79 193-16-9022 Sept 3 1925 pennsylvania Usual Residence of Deceden the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 271s marked other than "natural; or Items 23a or 28a-4 ehow any injury or other traumatic event, the Medical Exeminer must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16808 Petmar Circle 21742 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No11-26-43

If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced 5-16-46 Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Inspector 12 Truck Mfg 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 John Borum Mary Gendler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Barbara Borum (wife) 16803 Petmar Circle Hagerstown Maryland 21742 20a. Method of Disposition cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery | Apr 20 05 | Hagerstown Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Dye to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine anding physician and use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the at d be detached for 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 2 D MO or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 enesidence 6 Other (Specify) 1 Yes 2 No P 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Aatural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: Or the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person death (Item 23a) (Type, Print) 0 5H10+ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 20 2005 Registrar

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ALLEN WEBB M.D. 8579 COMMERCE DRIVE, EASTON, MD 21601  State  31. Date filed (Month, Day APR 1 2 2005 Register Signature						death (Item 23a) (Type	, Print)			•		
	8	)			3579 COMM	ERCE DRIVE		MD 21	1601			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jacquelyn Brice State of Maryland / Department of Health and Mental Hygiene 05 - 2546Certificate of Death Reg. No. AKG 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 11, Jacque1yn April 2005 9:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Prince George's Hospital Center Cheverly If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 9. Birthplace (State or Foreign (Month)) | 9. Birthplace (State or Foreign (Month)) | 9. Birthplace (State or Foreign (Month)) | 9. Birthplace (State or Foreign (Month)) | 9. Birthplace (State or Foreign (Month)) | 9. Birthplace (State or Foreign (Month)) | 9. Birthplace (State or Foreign (Month)) | 9. Birthplace (State or Foreign (Month)) | 9. Birthplace (State or Foreign (Month)) | 9. Birthplace (State or Foreign (Month)) | 9. Birthplace (State or Foreign (Month)) | 9. Birthplace (State or Foreign (Month)) | 9. Birthplace (State or Foreign (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) | 9. Birthplace (Month)) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F 53 Director Tennessee 411-90-1524 September Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at TYTYes 2 No Completed by Funeral Director MD Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 56th Place # 203 20737 5411 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Home Maker 12th nd 2 should be filed lith and Mental Hygi 27 Is marked other r traumatic event, II Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be E. Lyons ages 1 and 2 should bint of Health and Menta t: If item 27 Is marked y or other traumatic e Brice Grace Robert 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5411 56th Place # 203 Riverdale, Maryland 20737 Tiffany Cleveland/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or otl 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 4/23/05 Riverdale Crematory Riverdale, Maryland 21. Sign store of Funeral Service Libensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hyperfensive atherosclerotic Cardiovascular **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 5 Cher (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ØUnknown 24b. Were autopsy findings available prior to completion of cause of death?

(Valyes 2 \sum No 24a. Was an page 2 s autopsy performed? Yes 2 \( \square\) No 1X Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Yes 2 No XInpatient 2 ER/Outpatient 3□ DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1-Natural 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Medical

(Chack only one)

29b. Signature and title of certifier

completely

within 2

CABIULIAN 1 31. Date filed (Month, Day, Year)

APR 1 9 2005

30. Name and address of person who completed cause of death Item 23a) (Type, Print)

111 Penn Street Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

April 12, 2005

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number OCME

	-		1 - For State Registrar	State of Marylar		artment o				Re	g. No. 2	005	14814
	Physici		1. Decedent's Name (First, Middle, Las Andrea V. B	) Lagburn					2.	Date of Death Month April		2005 <sup>Year</sup>	3. Time of Death 14:52p M
	/Medi Examir		4a. Facility Name (If not institution, give 1802 Glendora Dr	street and number)		4b. City, To			ights	6	4c. Co	unty of Death Ince Ge	
	Funeral Director		5. Social Security Number 6. Se 578-56-7968	7 57	ast birthday) 2 Yrs.	If Under 1 Months E		Under 24 Hours	Hrs. 8. Min. Ju	Date of Birth (Month Day ine 17,	<sup>Y</sup> 1942	9. Birthr Cour Wash	place (State or Foreign ntry) nington, D.C.
	be filed within 72 hours after death with the Maryland hal Hyglene. od other than "natural", or Items 23a or 28a-f show event, I're Medical Examinar must be notified at	Funerai Director	10a. State 10b. County  Maryland Prince G  10e. Street and Number		y, Town or Lo					10	)g. Citízen	of What Cour	10d. Inside City Limits 1 1 Yes 2 □ No ntry?
	ath with	raiD	1802 Glendora Dr.			207	47				Unit	ed Stai	tes
920	urs after dea al', or items Examinar m	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Deceden f Yes, specify 1 ☐ Yes 2 ☒			n? (Specif Puerto Ric	y Yes or No- an, etc.)		Race - Americ Black, White, ecify: Blac	etc.
Maryland 21215-0036	C = -	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual C kind of work of DO NOT use	done durir etired)	ing most o				of Business/In	
d 2	Hygle other	Be Co	17. Father's Name (First, Middle, Last)	1	Admi	nistra				irst, Middle, N			Schools
ylan	S should be filed within and Mental Hyglene. Is marked other than aumatic event, If e M	To B	Andrew L. Radcli	ffe				F1o	rence	e Jacks	on		
	nd 2 suith ar		19a. Informant's Name/Relationship (T Leslie Blagburn	/ Son	1802	Glend	ora		Dist	oute Number, Cict He			20747
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 Other (Specify	Temoval Hom State	Place of Dispo cemetery, crer Linc		of r place)	4	Date / 20 / 2			on - City or To	
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Licens	James MOIN	77 22	Name and A 1exand 538 Ma	ddress of er S rIbo	ro Po	PeeFl	ineral Forestv	Home:	Md.A.	20747
	Physician /Medical		23a. Part. Enjer the disease, or comp shock, of heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. TYPE	2	er the mode o			ardiac or re	espiratory arre	st,		Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	b. Due to (or as a consequence of the period	uence of):		1					-	
,0928	cate be executed physician and the burial-transit	dicai Exa	that initiated events resulting in death) Last	Due to (or as a consect of the conse	uence of):			ere					
O. Box 6	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 morms? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of c	Ideath 3	Ectopic pregr Other (speci		-			23d.	Date of delive Month	ery Day Year
rds, P	signe d be	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying caus	se given in	n Part I.	_		acco use o	_	ne cause of death?
al Record		Completed						·		24a. Was ar autopsy perform 1 Yes 2	/	prior to co death?	psy findings available mpletion of cause of
Vital	9 9	o Be	25. Was case referred to medical examiner?	Hospital:			Other			Check only one			
of	ding After fune		1  Yes 2 No  27. Manner of Death  1  Natural 5  Pending 2  Accident investigation	1 ☐ Inpatient 2☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?	4 □ Nurs	28d	5 Pesider  I. Describe hor			ý) 
Division	ial or Attending s after death. al Director: After ad in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, str y)	eet, factory, o	ffice		28f.	Location (Str City or Town,	eet and Ni State)	umber or Rura	al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1X Certifying Phy (Check only one) 1 Medical Exam	rsician: To the best of my known iner: On the basis of examination and manner stated.	owledge, death	n occurred at t restigation, in	he time, o my opinio	date and ; on, death	place, and occurred	I due to the ca at the time, da	use(s) and te and pla	I manner as si ce, and due to	tated. o the cause(s)
	with To 1	Σ	29b. Signature and title of certifier				cense nu		_			gned (Month,	
3	- Tin		30. Name and address of person who o	ompleted cause of death (liter	n 23a) /Tune	Print)	/53	94	/		Apri:	L 18, 2	2005
1	(4)		Norann G.	actor 102	74 M	co MB	m o	way d	#202	lute	elle	lle, a	10.2072/
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 9 200	Registrar's Sign	ture 500	de							2005 N. 2072

		4	For State	State of Maryla		artment of tificate of		Mental Hy	giene Reg. No.		
			Registrar  1. Decedent's Name (First, Middle, Las	t)		timodio or	Dodin.	2. Date of De	eath 🚄	005	3. Time of Death
	Physicia		Michael	Paul	Po1	lesky		Month April	Day 1.3	Year 2005	6:36 P <sup>M</sup>
	/Medic		4a. Facility Name (If not institution, give		Del		or Location of Dea			county of Death	
	Examin	er	Holy Cross Hosp				Spring		Mor	ntgomer	v
	Funeral		5. Social Security Number 6. Se		s. last birthday)	If Under 1 Yea	r If Under 24 Hr	s. 8. Date of Bi	rth		place (State or Foreign ntry)
	Director		213-20-2433	XIM 2□F	80 Yrs.	Months Days	s Hours Mir	Jan. 24			yland
			Usual Residence of Decedent								
	nylan how		10a. State 10b. County	10c. (	City, Town or Lo	cation					10d. Inside City Limits
	a-f s	cto	Maryland Montgom	ery Si	lver Sp	ring					1 ☐ Yes 2 🔀 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cou	ntry?
	th wi	ai	2017 Forest Hil	1 Drive		1	0903			S.A.	
	ems err	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? ban, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	0- 14	<ol> <li>Race - Ameri Black, White</li> </ol>	
36	within 72 hours after death with the Maryland nne. Than "natural", or liems 23s or 28s-1 show na Modical Examiner must be notified at	ьу F.	1 ☐ Never Married 2 ☑ Married	1 ☑ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 🛣 No	o Specify:			Specify:	
21215-0036	ural'		3 Widowed 4 Divorced	Year or Dates: WW		dent's Usual Occ	unation		16b Kin	Wh: d of Business/Ir	ite
7	"nat	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	kind of work don DO NOT use retii	e during most of w	orking	100.10	Q 01 D03111033/11	idustry
12	withii ene. than	шć	Elementary/Secondary (0-12)	College (1-4or 5+)	Print		,		F	ederal (	Government
73	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural; or Hems 23a or 28a-f show other than "natural; or Hems 73a or 20a-f show event, the Marylan Examiner must be notified at	Ö	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle			00,021
Maryland	should be and Mental is marked o	0 0	Samuel Bellesky				Pear1	Trush			
<u></u>	shoul mar	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maifi	ng Address (Stree	et and Number or	Rural Route Numb	oer, City or	Town, State, Zi	p Code)
Š	od 2 lith a 27 is r trau		Irene Bellesky	/ Wife	2017	Forest	Hill Driv	ve, Silve	er Spi	ring, M	D 20903
e,	les 1 and 2 should be to the stand Mental I from 27 is marked or other traumatic every		20a. Method of Disposition		. Place of Dispo	sition (Name of matory or other p	(ace)	Date	20c. Loc	ation - City or T	own, State
Ë	Page ento		1 ☑ Burial 2 ☐ Cremation 3 ☐  14 ☐ Donation 5 ☐ Other (Specify	Removal from State  Ho			etery 4/	16/2005	Elkr:	idge, M	arvland
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot		21. Signature of Funeral Service Licen								1 Home, Inc
ä	Departing Department Important in any ir		· ala 1	Danuel	$\cup$ $ _{1}$	1800 New	Hampshi	re Ave.	Silve	r Sprin	g, MD 20904
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the de	ath. Do not en	ter the mode of d	ying, such as cardi	iac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cardiac Arı	vthmia						Onset and Death
	/Medical		resulting in death)	Due to (or as a cons							
	Examiner		Sequentially list conditions,	b. Pulmonary I	ailure						
	n =	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):						
	ecute ind trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Pulmonary I		3					
90,	e exe sien a urial-	ũ	1650itilig III death) cast	Due to (or as a cons	equence or):						
68760,	icate be executed physicien and s the burial-transit	edical	•	d							
			IF FEMALE:	23c. ff yes, outcome of pre-	manov					2d Data of dall	
Вох	attenc for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 F	etal death 3	Ectopic pregnar Other (specify)			2.	3d. Date of delive Month	Day Year
o.	at the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	i death St	_ Other (specify)					
Φ.	law requires that the death certif as been signed by the attending 2 should be detached for use ar		Part II. Other significant conditions of	ontributing to death but not	esulting in the u	inderlying cause	given in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
Records,	signed to be det	d by						1 🗆	Yes 2X	3No 3∏Pro	bably 4 Unknown
20	w require been si should b	Completed						24a. Wa	s an	24b. Were aut	opsy findings available
Rec	0 7 0	d L						auto	opsy formed?	prior to death?	ompletion of cause of
a		e Co	25. Was case referred to medical				OF Place of F	1 ☐ Yes Death (Check only	2 No	1 🗆 Yes	2 No
Vital	Physician: this certific ral director,	o Be	examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	☑ ER/Outpatie	nt 3 DOA	thor	Home 5 Res		□Other (Spec	ifv)
of		-	27. Manner of Death	28a. Date of Injury	28b. Time o			28d. Describe			
OU	토 중 등	tio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year	) Injury		/ork? □Yes 2□No				
Division	Attending or death.	ifice	3 ☐ Suicide 6 ☐ Could not b	288. Place of injuly - A		reet, factory, offic	28		(Street and own, State)	Number or Ru	ral Route Number,
Di	s afte	Certification:	4 Homicide	building, etc. (Spe	ony)			Sily of T	J.T., Olaid)		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the			ysicien: To the best of my l							
	in 24 in 24 ihe Fi	Medical	one)	and manner stated.	mation and/or in			Control of the fulls			
	To t To t	Σ	29b. Signature and title of certifier	11041			ense number		29d. Date	signed (Month	, Day, Year)
•	12			14 10		D	16477		Apr	il 15,	2005
	( -		30. Name and address of person who	1 1			_			0050	
			Dr. Joel L. Goo				Rockvill	e, Maryl	and 2	0852	
	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 18 2	005 Registrar's Si	S. G	ask					

	_1	State Registrar		larylan	id / Depa	artmen rtificate			ind M		Reg. No. 2	00!	5 [48]
Physicia: /Medica Examine	n al	1. Decedent's Name (First, Middle, Last,  Elsie Ber  4a. Facility Name (If not institution, give	man	·)		4b. City,	Town, or	Location of	f Death	2. Date of De Month	Day / 4	Year 200	5 4:001
Funeral		SHADY GROVE ADVENT	TIST HOSP	ITAL	last birthday)	ROC		LE If Under 2		8. Date of Bin	th	TGOME	
Director		088-03-5953	]M 2∏F	92	Yrs.	Months	Days	Hours	Min.	(Month, Da OCT 24,	y, Year) 1912	NE	rthplace (State or Fore country) W YORK
Ba-f show	.	10a. State 10b. County  MARYLAND MONTGOME	ERY		y, Town or Lo								10d. Inside City Lim
the or 2	2	10e. Street and Number  1515 DUNSTER ROAD,	#23			10f. Zip	Code 20854				10g. Citizer		,
o'ag	by Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1  Yes 2 K If Yes, Give Year or Dates:	? No			dent of Hi		gin? (Spe , Puerto F	cify Yes or No Rican, etc.)	- 14.	ED ST. Race - Am Black, Wh	nerican Indian,
ene. than "natur na Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		5+)	16a. Deced (Give life.	dent's Usua kind of wor DO NOT us HOMEM	rk done d se retired,	u <i>ring</i> most )	of workin	g		of Busines:	,
Mental Hygi arked other stic event, 1	To Be Co	17. Father's Name (First, Middle, Last) MORRIS	LEVINE		1			18. Mother	r's Name CHER	(First, Middle,	Maiden Su		
Heelth and tem 27 is ma other treums	_	19a. Informant's Name/Relationship (Ty ESTELLE R. BERMAN, 20a. Method of Disposition	DAUGHT	20b. F	27 TR	EWORT	HY R	OAD,	GAIT	HERSBU	RG, MI	20	Zip Code) 878 r Town, State
Department of I		1  Burial 2  Cremation 3		3	MONTE	FIORE	E CEN	1. 4/	/20/2	2005 DIREC	PINEL	AWN,	L.I., NY
Medical caminer	_	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	THE CAUSE OF CAUT	s a conseq	th. Do not ent	091 R	LOCKV	ILLE	PIKE cardiac or	. ROCK	VII.I.E.	, MD	20852 Approximate Interval Between Onset and Death
igned by the attending p be detached for use as	Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome  1 Live birth  4 Pregnant a  9 Unknown	2 Feta	Ideath 3□	Ectopic pre Other (spe					23d	. Date of de Month	elivery Day Year
n signed b	d by Pr	Part II. Other significant conditions con	ntributing to death	but not res	ulting in the u	nderlying ca	ause give	n in Part I.			obacco use		to the cause of death?
sete has been sin	Completed											4b. Were a prior to death?	utopsy findings availat completion of cause of
his cer	0	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1-Natural 5 Pending 2 Accident investigation	lospital: 1 Inpat 28a. Date of Inj (Month, D		ER/Outpatien 28b. Time of Injury		8c. Injury Work	r: 4□ Nur at	sing Hom	(Check only only only only only only only only	lence 6		ecify)
s efter death.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inbuilding, e	njury - At ho tc. (Specif	ome, farm, str	eet, factory	, office		2	8f. Location (S City or Tox		umber or A	lural Route Number,
within 24 hours of To the Funerel D completely filled i	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the bes ner: On the basis and manner s	of examina	wledge, death tion and/or inv	occurred a restigation,	at the time in my op	e, date and inion, death	l place, ai h occurre	nd due to the o d at the time, o	cause(s) and date and pla	d manner a ce, and du	s stated. e to the cause(s)
To th comp		29b. Signature and title of certifier	· nent	n		29c.	. License	number 154	9		29d. Date si	1	th, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Elena C. Biederman April 2005 14, /Medical 5:30 P. 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kensington Park Kensington
Inder 1 Year | If Under 24 Hrs. |
Iths Days | Hours | Min. | Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months 1 ☐ M 2 😿 F Director 218-32-5857 93 Oct. 7, 1911 Pennsylvania Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. The processing from 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Middeal Examplement. 10525 Grove Ridge Place Funeral 20852 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify: Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Music Teacher Private Lessons 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Vincenzo Crivella Lucia D'Amore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucia C. Biederman 10525 Grove Ridge Place Daughter Rockville, Maryland 20852 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Apr. 18, 2005 Silver Spring, MD Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901 23a. Part1. Ent. the disease, or complemions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Woress Onset and Death Immediate Cause Final QU Voliaic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner therosclent c Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit 2 mentra resulting in death) Last Due to (or as a gonsequence of): Division of Vital Records, P.O. Box 68760, Exhermer's. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 12 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 2 Accident investigation 1 Yes 2 No filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie cal (Check only Medi one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12 D53691 April 15, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajay P. Reddy, M.D., 6320 Democracy Blvd., Bethesda, Maryland 20817 31. Date filed (Month, Pay, Year)

APR 18 2005 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 105

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i> i	artment of H			ene U5	14818
	Dhysisi	200	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	Physici: /Medic			<del>-</del>	Graham Bro	wn		04	16 05	
1	Examin	er	4a. Facility Name (If not institution, give s		_		r Location of Death		4c. County of De	ath
			Montgomery Genera  5. Social Security Number 6. Sex	<del>-</del>		O]	Lney  If Under 24 Hrs.	0.0.1.1(0:11)		tgomery
	Funeral Director			7. Ag	e (In yrs. last birthday) 74 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, March 4,	1931 I	lirthplace (State or Foreign Country) 111inois
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Many a-f sh	tor	Maryland Montgom	erv	Laytonsvi	11e				1 ☐ Yes 2 🔀 No
	th the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (	Country?
	23a		8716 Deanna Drive			2	20882		United S	tates
	tems	Funeral		12. Was Decedent I Armed Forces?		Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ ! If Yes, Give Year or Dates: }		1 ☐ Yes 2 ☒ No	Specify:		Specify:	71. 3 4
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show the Modical Examiner must be notified at	ted t	15. Decedent's Edu	cation	16a, Dece	dent's Usual Occup	ation	1	6b. Kind of Busines	White ss/Industry
215	hin 7.	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	(Give	kind of work done o DO NOT use retired	durina most of worki	ng		,
21	ygiene gerth	Completed		4		ice Offic	cer	1	Montgomer	y County
nd	12 should be filed within h and Mental Hygiene. 7 is marked other then " reumatic event, Ire Mas	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		aiden Sumame)	
yla	d Men darke narke	은	Walter E. Brown	Dried	401 147		Helen Gra			
Maryland	d 2 sl th an th an treur		19a. Informant's Name/Relationship (Ty Jean P. Brown/ Wif	•			and Number or Rura rive, Layt			
ā,	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f show or other treumatic event, the Madical Examinar must be notified at	1	20a. Method of Disposition		20b. Place of Dispo	sition /Name of	1 0		Oc. Location - City of	
9	Pages nent of h int: If its		1 ☐ Burial 2 ☑ Cremation 3 ☐ R  `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Metropoli	natory or other place tan Crema	4/19,		lovandria	, Virginia
Baltimore,	# E # E		21. Signature of Funeral Service License	99	22	2. Name and Addres	ss of Facility			
Ω_	Dep Imp		- Jade OW	men		in L. Mo. 401 Ridge	lesworth I e Road, Da	amascus,	neral Hom Maryland	e 20872
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	tions that caused cause on each lin	the death. Do not ent	er the mode of dyin	ig, such as cardiac c	r respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	A	rchyth	mia				Onset and Death MINUTES
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					20 320
		-E	Sequentially list conditions,		ypertension	l .				YENKS
	uted I Insit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	55010 (0. 45	a 00.100400.100 01).					
Ć.	exectin and ial-tra	Examiner	resulting in death) Last		a consequence of):					
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical								
	ing ph		IF FEMALE:							
Вох	eath cert attending for use a	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy	,		23d. Date of d Month	lelivery Day Year
	res that the de signed by the a be detached f	Physician/N	1 Yes 2 No	4□Pregnant at 9□ Unknown	time of death 5L	Other (specify)				
P.0	that the by detail		Part II. Other significant conditions cor	tributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
Records,	quires n sign ald be	d by	Diabetes					1 ☐ Yes	2 □ No 3 □ I	Probably 4 Monknown
000	aw requir s been si s should	ojete						24a. Was an	24b. Were	autopsy findings available
Re	The lav	Completed						autopsy perform	prior to ed? death?	completion of cause of
Vital		Bec	25. Was case referred to medical examiner?				26. Place of Death			33 20110
of V	di isi	Tof	1 Yes 2□ No	ospital: 1 🗌 Inpatie			er: 4 ☐ Nursing Hor	me 5 🗆 Resider	ce 6 □Other (Sp	necify)
n o	ding Ph h. After th funeral	iuo]	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time o	Worl	k?	28d. Describe how	vinjury occurred	
Division	ttend death stor: /	Icat	2 Accident investigation 3 Suicide 6 Could not be	29o Plane of Ini	ury - At home, farm, str		Yes 2 □ No	296 Location /Stee	ot and Number or I	Rural Route Number,
Dί	of or A after Direct tin by	Certification:	4 Homicide determined	building, et	c. (Specify)	eet, factory, office		City or Town,	State)	nurar noble Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 Certifying Phys	sician: To the best	of my knowledge, deat	n occurred at the tin	ne, date and place, a	and due to the cau	ise(s) and manner a	as stated.
	he Ho in 24 he Fu pletel	Medical	(Check only 2 ☐ Medical Examination one)	ner: On the basis of and manner sta	f examination and/or in	vestigation, in my o	pinion, death occurre	ed at the time, dat	e and place, and du	ue to the cause(s)
	Vith To 1	Σ	29b. Signature and title of certifier	\	D	29c. License			d. Date signed (Mor	
)				+ M.	U .	DO	058770		April 16	, 2005
	Š		30. Name and address of person who co		leath (Item 23a) (Type,		123			w 3 3
	Sta	to		1 810 1 Py	rine Philipar's Signature	Prive	Ulney	MARYL	AND 20	332
	Registr		31. Date filed (Month, APR eal 9 2	1005	gree At	Grank ?				

			1 - For State Registrar	State of Mar	-	artment of Hertificate of E		Mental Hygie	2005	14819
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Las  Mary Jane Bouchel  4a. Facility Name (If not institution, give	.le		4b. City, Town, or I			Day Year 8 2005 4c. County of Dea	
	Funeral Director		Social Security Number     6. Social Security Number		(In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Nov. 3, 19	ear) 9. Bir	thplace (State or Foreign ountry) yland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show any injury or other treumetic event, it is Medical Exempter was be notified at once.	To Be Completed by Funeral Director	Maryland Cecil  10e. Street and Number  48 Bouchelle Road  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ec (Specify only highest gra  Elementary/Secondary (0-12)  11  17. Father's Name (First, Middle, Last)  Benjamin Bryan  19a. Informant's Name/Relationship (1)  Alton Bouchelle/H  20a. Method of Disposition  1 Burial 2 Cremation 3 Companion 1 Compa	12. Was Decedent Ev Armed Forces? 1	16a. Dece (Give life.) Homen 19b. Mailir 48 Bo 20b. Place of Dispo complete, orer North Eas 22	In the state of th	American, Puerly Specify:  Ition Iti	pecify Yes or No- o Rican, etc.)  Interpretation of the pecify Yes or No- o Rican, etc.)	m Home den Sumame)  ity or Town, State, a  ryland 21 c. Location - City or  rth East,  ral Home  East, Mary	tes prican Indian, re, etc.  hite Vindustry  Zip Code)  1901 Town, State  Maryland Vland 21901
8760,	Physician /Medical Examiner  whysician and physician and the prival-transit the prival-tr	dicai Examiner	23a. Part. Enter the disease, or composition, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a c	PSIS ·	ENAL CO	FAIL	URE.		Approximate Interval Between Onset and Death 1 Month 1
P.O. Box 68	t the death certific by the attending p tached for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3 Inne of death 5 Inne	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
Vital Records,	The law requires that ate has been signed page 2 should be del	Completed by	Part II. Other significant conditions of	ntributing to death but	not resulting in the u	nderlying cause giver	n in Part I.	1 ☐ Yes  24a. Was an autopsy performed	2 No 3 Pr	othe cause of death?  obably 4 □Unknown  utopsy findings available completion of cause of
Division of Vital	or Attending Physicien: ter death. irector: After this certifics o by the funeral director, p	Certification; To Be Co	25. Was case referred to medical examiner?  1 Yes 2 10 6  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	Hospital: 1 Pinpatient 28a. Date of Injury (Month, Day ) 28e. Place of Injury building, etc.	28b. Time of Injury	28c. Injury a Work?	4 ☐ Nursing H	th (Check only one) ome 5 Residence 28d. Describe how in 28f. Location (Street City or Town, S	e 6 □Other (Speniury occurred	cify)
_	To the Hospitel of within 24 hours at To the Funerel D completely filled in	Medical Ce	29a. Certifier (Check only one)  29b. Signature and title of certifier	ysician: To the best of riner: On the basis of eigendand manner state	xamınation and/or inv d.	occurred at the time vestigation, in my opin 29c. License	nion, death occu	rred at the time, date	and place, and due	to the cause(s)
	Sta Registr		30. Name and address of person who of ALOK RUSTOG 31. Date filed (Month, Day, Year)	I, MD	UNION	HOSPIT	AL OF			, ELKTON

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, MARY JANE

BOUCHELLE

			1 - For State of Maryland / Department / Department / Department / Department / Department / Department / Department / De	artment of Health and Mental rtificate of Death	Hygiene 200	5 14820
	Physic /Medi			2. Date Moni	of Death h Day Yea	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number) Washington County Hospital	4b. City, Town, or Location of Death  Hagerstown	4c. County of De Washin	
	Funeral Director		5. Social Security Number  217-42-8905  Usual Residence of Decedent  6. Sex 1 M 2 F  7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year   If Under 24 Hrs.   8. Date (Mon Oct.)	iii, Day, rear)	Sirthplace (State or Foreign Country) aryland
	ne Maryland 8a-f show	Director	10a. State 10b. County 10c. City, Town or Lo	erstown		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with th	al Dire	10e. Street and Number 315 S. Potomac Street	10f. Zip Code 21740	10g. Citizen of What	Country?
920	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: it Item 27 is marked other than "natural", or items 23a or 28a-f show apply injury or other traumatic event, it is Maclical Examinar must be rotified at ODGE.	by Funeral	3 ☐ Widowed 4 ☐ Divorced	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et     □ Yes 2 No Specify:		nerican Indian, nite, etc. white
21215-0036	within 72 ho lene. Ithan "natur Ite Modical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  11  College (1-4or 5+)  CO	dent's Usual Occupation kind of work done during most of working DO NOT use retired)  NStruction	16b. Kind of Busines	,
	be filed htal Hygi od other event, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M		ion company
Maryland	should nd Mer marke	٦ ۲	unknown  19a. Informant's Name/Relationship (Type, Print)  19b. Mailin	unknown  ng Address (Street and Number or Rural Route N	lumber City or Town State	Zin Cada
	ss 1 and 2 of Health a item 27 is other tras		Peggy Jean Cornell - wife 315  20a. Method of Disposition 20b. Place of Dispo	S. Potomac St., Hagers		740
altimore,	t. Page rtment c rtant: tf		`4 □ Donation 5 □ Other (Specify) Rose Hil	1 Cemetery 4-22-05		wn, Maryland
Ba	Depariment Department on in poore			Name and Address of Facility MINN 15 E.Wilson Blvd., Hag	IICH FUNERAL	
	Physician /Medical		23a. Part 1. Enter the disease, of complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	er the mode of dying, such as cardiac or respirate	ory arrest,	Approximate Interval Between Onset and Death
	Examiner	-	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):			(
8760,	cate be executed physician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):			
.O. Box 68	The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as the	Physician/Medio		Ectopic pregnancy Other (specify)	23d. Date of de Month	blivery Day Year
rds, P.	w requires that been signed be should be det	þ	Part II. Dther significant conditions contributing to death but not resulting in the un		Did tobacco use contribute t	o the cause of death?
		Completed			autopsy prior to performed? death?	utopsy findings available completion of cause of
	ysician: The is certiticate director, pag	To Be	25. Was case referred to medical examiner?  1  Yes    No    Hospital: 1	26. Place of Death (Check of DOA)		2016.1
o uois	Hospital or Attending Physicien: 44 hours after death. Funeral Director: After this certific tely tilled in by the tuneral director,	ertification;	27. Manner of Death    1	28c. Injury at Work? M 1 Yes 2 No	ibe how injury occurred	ecny)
DIVIS	ital or Attend us after death ral Director: , led in by the t	0	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	City or	on (Street and Number or R r Town, State)	
	To the Hospital within 24 hours a To the Funeral I completely tilled	Medical	29a. Certifier (Check only one)  Construction  Constructio	estigation, in my opinion, death occurred at the ti	the cause(s) and manner ame, date and place, and due	s stated. e to the cause(s)
	5 × × × ×	-	29b. Signature and title of certifier	29c. License number  MN 37949	29d. Date signed (Mont	
41	116		30. Name and address of person who completed cause of death (Item 23a) (Type, F	,	April 20,	2005
	Sta		Dr. Steven Hatleberg, 11110 Medical C		Md. 21742	
4	Registra	ar .	APR 2 1 2005 Jane 1. Sp	exe		

			For State Registrar		State	of Mary	yland /	-		nt of H			/lental				
			Decedent's Name (First, Middle	e, Last)						10 01 1	Journ		2. Date	of Deat		<b>CUU</b>	3 Time of Death
	Physici		Ismac Stanler										Mon		Day		M
	/Medic Examin		James Stanley 4a. Facility Name (If not institution			umber)			4b. Cit	, Town, or	Location	of Death				2005 County of Deatl	10:44 A
			Washington Ad	vent	ist F	Jospii	ta1		т	akoma	Par	k				Montgom	227
	Funeral		5. Social Security Number	6. Sex			n yrs. last l	birthday)		er 1 Year	If Under Hours		8. Date	of Birth		9. Birth	nplace (State or Foreign
	Director		579-01-7544	1131	M 2□F	9	)4	Yrs.	WOIGH	Days	riouis	iviit i.	Apri				ington,DC
	and *	}	Usual Residence of Decedent  10a, State 10b, County			10	0c. City, To	wn or Loc	ration								10d. Inside City Limits
	Aaryli ebo	5	, , ,														1 ☐ Yes 2 ☑ No
	28a-	ect	Maryland Prince	e Geo	orge'	s	T.	akoma		rk ip Code				1	Do Citi	zen of What Co	
	d within 72 hours after death with the Maryland plans.  Jiens. Than "naturat, or Items 23a or 28a-f ehow the Medical Examiner must be notified at	Funeral Director							101. 2		0			'	og. Cili		antry?
	ns 23	era	1514 Delmont La		2. Was De	cedent Eve	er in U.S.	13. V	Vas Dec	2091 edent of Hi		rigin? (Sp	ecity Yes	or No-	T	USA 14. Race - Amer	ican Indian
0	ther of the contract of the co	Fun	1 Never Married 2 Mar		Armed F 1 ☐ Yes	orces?		If	Yes, sp	ecify Cuba	n, Mexica	n, Puèrto	Rican, e	tc.)		Black, White	
<u> </u>	al', o	by	3 ☐Widowed 4 ☐ Divorced		If Yes, G Year or	live Dates:		1	☐ Yes	2 🔯 No	Specify.	:				Specify: Wh	ite
21215-0036	72 ho	Completed	15. Deceder (Specify only highe			n	16			ual Occupa		et of work	ring		16b. Ki	nd of Business/I	
21	within 72 ene. than "ner ne Medic	nple	Elementary/Secondary (0-12)	1		(1-4or 5+)		life. D	NOT	use retired	)	31 01 11011	ung				
2	ygier ygier yer th	Cor	6					Bakeı	c						Bak		
ב	be fil Ital H Id ott	Be	17. Father's Name (First, Middle,	Last)							18. Moth	er's Nam	e (First, A	Aiddle, N	Maiden	Sumame)	
Maryland	ould Mer narke	မ	William Dorsey								Mi	nnie	Not	Ava	ail:	able	
<u>a</u>	12 st h and 7 ls n traun		19a. Informant's Name/Relations			_										r Town, State, Z	ip Code)
ტ —	Healt C		James Bradley 20a. Method of Disposition	Cant	er	Son	20b. Place			ont L	ane	Tak	oma I			aryland cation - City or 1	20912
و	ages nt of nt of		1 ⊠Burial 2 ☐ Cremation		moval fron	- 1	ceme	terv. crem	atory of	other place emete	1° 37			- 1		,	
altimore,	it. Pi		' 4 ☐ Donation 5 ☐ Other (S							and Addres			16,20	005_	Sui	tland,Ma	aryland
Ba	permit. Pages 1 and 2 should be filed with bogestment of Health and Mental Hygien Important: if I tem 27 is marked other II eny Injury or other traumatic event, II appre.		VWill E		u (	4		Fra	inci	s J.	Co11:	ins	Funer	al	Hom	e, Inc.	
			23a. Part1. Enter the disease, or	r complic	ations that	sused the	e death. D									Spring,	MD 20901 Approximate
	Obveision		shock, or heart failure. List Immediate Cause (Final	only one	e cause on	each line.								,	,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	_ a.		ctensi			Dis	ease							
	Examiner					cioscl		theory.								1	
_		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	<b>)</b> b.		o (or as a co											
	cuted nd ransii	Examin	Cause (Disease or injury that initiated events	c.	Peri	heral	l Vas	cular	Di	sease							
Ö,	e exe ian a urial-i	EX	resulting in death) Last		Due to	o (or as a co	onsequenc	e of):									
8760,	rcate be executed physician and s the burial-transit	dicai		d.													
Θ ×	ling p		IF FEMALE:	-													
Вох	eath certifi attending I I for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23	1 Live	utcome of p	Fetal dea			pregnancy					2	3d. Date of deli-	very Day Year
o.	at the de by the a tached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Preg 9☐ Unk	nant at tim nown	e of death	5 🗆	Other (	specify)							,
٠.	The law requires that the death certif tte has been signed by the attending age 2 should be detached for use a		Part II. Other significant conditi	ons cont	ributing to	death but n	not resulting	g in the un	derivina	cause dive	n in Part I	l.	23e	. Did tob	acco u	se contribute to	the cause of death?
ecords,	uires I sign Id be	d by			_				, ,	•							ibabiy 4 🛣 Unknown
00	w require been sig	Completed											240	. Was a		Oah Wara au	
He E	The lav	dmo											240	autops	y	prior to death?	opsy findings available ompletion of cause of
		e Co	25. Was case referred to medica								ac Di-	- of Door		Yes 2		1 🗆 Yəs	2 No
>	9 5	0 B	examiner? 1 X Yes 2 No	-	ospital:	Inpatient	2 🔯 EB/0	Outpatient	3 🗆 [	Othe	20		h (Check			3 □Other (Spec	4.1
ō	g Phy erthii eral c	n: T	27. Manner of Death		28a. Date	of Injury	28b	. Time of	0_ 0	28c. Injury Work		draing the				occurred	ny/
<u>o</u>	death. ctor: After y the funer	atio	1 XNatural 5 ☐ Pendir 2 ☐ Accident investi	gation	[////	nth, Day Ye	ear)	Injury	М		r res 2□	No					
Division of	er de recto by th	Certification;	3 Suicide 6 Could 4 Homicide determ			e of Injury		farm, stre	et, facto	ry, office				tion (Sti			ral Route Number,
	Ital o rs aft ral DI	Cer												_	, 51010,		
	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	icai	(Check only 2 Medical	ng Physi Examin	ician: To the	ne best of m	ny knowled	lge, death	occurre	d at the tim	e, date ar	nd place,	and due	to the ca	use(s)	and manner as place, and due	stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one)	-	and ma	nner stated	1.						(110				
	To To	~	29b. Signature and title of certifie	1//	1	4			12	c. License	number			29	d. Dat	e signed <i>(Month</i>	, Uay, Year)
	3		ruce	Il		lee		11		D 57	614				Apr	11 15,20	005
	/		30. Name and address of person				-	a) e, F	,								
	Sta	to	Don Coleman, M 31. Date filed (Month, Day, Year,	.D	7.60	0 Car	croll Signature	Aver			ma Pa	ark,	Mary	lano	d2	20912	
	Registi		31. Date filed (Month, Day, Year, APR 18	200!	5 /4	Registrar's	Ji.	Kon	ALL S								

			For State		State of M	1arylan		artment of H		Mental Hy	giene		
			Registrar  1. Decedent's Name	(First, Middle, Last)			Cel	lilicate of i	Jealii	2. Date of D	Reg. No.	2005	3. Time of Death
	Physici			sanna Cof	iell					A Pres	Day	Year 2005	1/ 39 AM
	/Medic Examin		4a. Facility Name (If			r),		4b. City, Town, or	Location of Dea		4c.	County of Death	11.5/4
	,		SACRE	DHE	ART H	1054	PITAL	Cum.	berlar	id		ALLE	3-ANY
	Funeral Director		5. Social Security No. 218–16–28	1	7. A	ige (In yrs. 81	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth ay, Year) 1923	9. Birthi Coul Mary	
	and		Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Maryli f sho	0	MD	Garrett			ntsvil					}	1 ☐ Yes 2 ☐ XNo
	the	rec	10e. Street and Num					10f. Zip Code			10g. Citi	zen of What Cou	ntry?
	th with	al D	331 River	Road				21536				USA	
36	be filed within 72 hours after death with the Maryland that Hygiene. So other than "neturel", or items 23e or 28e-f show event, the Medical Eventing frust te notified at	by Funeral Director	11. Marital Status  1 ☐ Never Marrie 3 ☑ Widowed	ed 2 Married	12. Was Deceden Armed Forces 1 Pyes 2 If Yes, Give	? 3/3 5/	22/43-1	Was Decedent of H I Yes, specify Cuba I □ Yes 2 🕱 No	ispanic Origin? ( in, Mexican, Pue Specify:	Specify Yes or Note Rican, etc.)		14. Race - Ameri- Black, White, Specify:	
21215-0036	turei'		3 NVIdowed	15. Decedent's Edu	Year or Dates	: -,		ient's Usual Occup	ation			W	nite
15	uln 72 n "ne n "ne	Completed		fy only highest grade	e completed)		(Give	kind of work done of NOT use retired	during most of wo	orking	IDD. KI	nd of Business/In	dustry
212	e filed within at Hygiene. other than "vent, the Me.	mo	Elementary/Secon	idary (0-12)	College (1-4or	(5+)	Owner/	Operator			Tave	ern	
	be filed ta! Hygi of other event, I	Be C	17. Father's Name (	First, Middle, Last)					18. Mother's Na	me (First, Middle	. Maiden	Sumame)	
yla	should be nd Menta r marked umetic ev	To	Roy Wilbu						Grace H				
Maryland	2 ar ar 6			me/Relationship (Ty	•		Li-	g Address (Street					
	s 1 and if Health item 27 other tr		Madeleine 20a. Method of Disp	Dorsey/I	Daughter	20h F	-	caway Rd.	, Reiste	rstown,		rland 21	
Baltimore,	0 0		1 🗆 Burial 2 🖁	¶Cremation 3 □R	emoval from State	e _ c	emetery, cren	natory or other place Side Crem				idsville	
Ē	- E # -			5 □ Other (Specify) ne <b>vá</b> l Service License	98	100			s of Eacility N	ewman Fr	nera	1 Homes	PA D A
Ba	Depa impo any is				Ouma	w	Pa	179 Milli O. Box 2	er St., 75. Gran	tsville	Mar	vland 21	536
			23a. Part1. Enter th	e disease, or compli	cations that cause	ed the deat						yrana zi	Approximate
	Physician	) 2 114	Immediate Cause disease or condition	final \	Ather	me.	بطمت		liovas	- 100			Interval Between Onset and Death
4	/Medical		resulting in death)		Due to (or a	s a conseq	uence of):	CWA	wio vas	aur	VISE	ase	= years.
Н	Examiner		Sequentially list con	ditions.	)								
	sit ad	Examiner	Sequentially list con if any, leading to im cause. Enter Under Cause (Disease or i	tying	Due to (or a	s a conseq	uence of):						
_	xecut and Il-tran	xan	that initiated events resulting in death) L		Due to (or a	s a conseq	uence of):						
68760,	icate be executed physician and the burial-transit	alE		l l			201100 0171						
687		edical											
Вох	death certific e attending pl d for use as t	n/M	IF FEMALE: 23b. Was decedent	pregnant 2	3c. If yes, outcom			n=			2	23d. Date of delive	ery
	0 0 0	Physician/M	in the past 12 1 Yes 2 D	ponths?	1 Live birth			]Ectopic pregnancy ] Other ( <i>specify</i> )				Month	Day Year
P.O.	that the dead by the detached	hys	9 🗆 Unknown		9Ll Unknown								
	es be	by F	Part II. Other signifi	cant conditions cor	ntributing to death	but not res	ulting in the ur	nderlying cause give	en in Part I.				he cause of death?
ord	w requir been si should	ted								10	Yes 2	□No 3□Prob	pably 4 Unknown
Records,	elaw hasb je 2 st	Completed							· · · · · · · · · · · · · · · · · · ·	24a. Was	psy	prior to co	psy findings available mpletion of cause of
alF	Th ate pag									1 ☐ Yes	2[XNo	death?	21 <b>X</b> No
Vital		Be c	25. Was case referr examiner?		fospital:		<b>*</b>	Oth		ath (Check only			
of	Phys	. To	1 ☐ Yes 2 🔀		1 Inpat	jury	ER/Outpatien 28b. Time of	t 3 DOA 28c. Injun	4   Nursing	lome 5 Res 28d. Describe		Other (Specify occurred	(y)
ion	Attending Phyrdeath. ector: After thi	atlor	1 Natural 2 Accident	5 Pending investigation	(Month, D	ay Year)	Injury		k? Yes 2 □No				
Division	<b>⋖</b> ≈ <b>8</b> 6	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In	nju <b>ry</b> - At he	ome, farm, str	eet, factory, office		28f. Location ( City or To		d Number or Rura	I Route Number,
ā	ital or rs afte ral Dir	Cer								0.1, 5. 10	, O.0.0)		
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	Medical	29a. Certifier (Check only one)	Certifying Phys	sician: To the bes ner: On the basis and manners	of examina	wledge, death ition and/or inv	occurred at the time time of the stigation, in my of	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as s place, and due to	tated. the cause(s)
	To the within 2. To the complet	Me	29b. Signature and	title of certifier	-			29c. License	number		29d. Date	e signed (Month,	Day, Year)
	p= ≤  == Ö		> w	mock	fhi	,	MD	00	05532	5		pril 18	
1	AVI			ess of person who co	maleted seven of	death (Iter	n 23a) (Type,	Print)					
1	a '		WONSOC	K SHIN	1 MD	48 T	eurn Te	errace	Frestl	wy M	1221	532	
	Sta		31. Date filed (Mont	n, Day, Year) APR 2 0 2	32. Regis	trar's Signa	ature	1 4		0			
	Registi	ar		WILL MAN A T	000	Cape.	1.30 M	73000					

			1- State of Marylar Registrar		artment of Health and rtificate of Death		ene . No. 2 A A A	5 11000
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  Augusta Lee Davis		th Ch. Tara and antica of Da	2. Date of Death Month April 8	Day Year 2005	1:10p M
			4a. Facility Name (If not institution, give street and number)  Southern Maryland Hospit  5. Social Security Number 6. Sex 7. Age (In yrs.		4b. City, Town, or Location of Dea Clinton  If Under 1 Year  If Under 24 Hr	S Q Date of Birth	4c. County of Dea	Georges
	Director		415-26-5291 1 M 2 F 83 Yrs. Months Days Hours Min. April Day Year) 1921 Tenn Usual Residence of Decedent					
Itimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Heath and Mental Hygiene. Importent: If then 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other treumatic event, it is Madical Examinat must be indifficial at once.	ctor		apito	l Heights			10d. Inside City Limits  X☐ Yes 2☐ No
		Funeral Director	10e. Street and Number 510 Millwheel Street		10f. Zip Code 20743		nited S	
		Completed by Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in L Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify:	(Specify Yes or No- arto Rican, etc.)	14. Race - Am Black, Wh Specify: B	
			15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  5 +	(Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired) DOL Teacher	rorking	etroit I	Sub. School
		To Be C	17. Father's Name (First, Middle, Last) Ambrose Whitlow		Etta	ame (First, Middle, Ma Mae Tay	lor	
			19a. Informant's Name/Relationship (Type, Print)  Hellen Beard/grand niece  20a. Method of Disposition 20b.	19b. Mailir 510 Capi	ng Address (Street and Number or A Millwheel Str Ltol Heights, astion (Name of		City or Town, State,  3 c. Location - City o	
			'4 Donation 5 Other (Specify)	surrec	sition (Name of malory or other place) ction Cem. 4/1	5/05 C	linton,	Md
Ba	Depar Impor		21. Sinatur of Funeral Service Licensee	/ 39	2. Name and Address of Facility 910 Silver Hil	l Rd., Si	uitland,	
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, or heart failure. List only one cause on each line.    Physician   / Medical							Approximate Interval Between Onset and Death
Records, P.O. Box 68760,	tel or Attending Physicien: The law requires that the death certificate be executed Xa stafer death.  As after death.  As after death.  As after death.  By the funeral director, page 2 should be detached for use as the burial-transit of the page.	ation: To Be Completed by Physician/Medical Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	quen of):	us us disea	se		meels.
			Due to (or as a donsed d.	quence of):				0
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant at time of the pregnant at time at time at the pregnant at time at the preg	al death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	elivery Day Year
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to 1  1 Yes 2 No 3 Pro					to the cause of death?  Probably 4 Unknown
						24a. Was an autopsy performe	prior to	
			25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2	∃ER/Outpatien	Othor	eath (Check only one)		
			27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	3 DOA Corlet. 4 Nursing Home 5 Residence 6 Other (Specify)  28c. Injury at Work?  M 1 Yes 2 No		ecity)		
		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street an City or Town, State				Rural Route Number,	
	To the Hospitel or within 24 hours after the Funerel Dir completely filled in it.	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my kn (Check only one)  Certifying Physician: To the best of my kn (Check only one)	owledge, death ation and/or in	h occurred at the time, date and place vestigation, in my opinion, death occurred.	ce, and due to the caus curred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To t To t	×	29b. Signafure and title of certifier  29c. License number  29d. Date signed (Month, Day, 1)  29d. Date signed (Month, Day, 1)  29d. Date signed (Month, Day, 1)					nth. Day, Year)
12	- (6)		30 Warne and address of person who completed cause of death (Ite	Aut	Print) Place Se	uitland	Md	20746.
	Sta Registr		31. Date filed (Month, Day, Year)  22. Registrar's Sign  APR 1 9 2005	ature	K)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Herbert Charles Deggendorf 2005 15 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PONIASULA Alcomico Medical 501155419 egiona If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) 6. Sex Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 10XM 2□F Director 482-16-8186 Usual Residence of Decedent February 20,1924 Iowa 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28e-f show treumatic event, the Madical Examiner must be notified at 1 Yes 2 XNo Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 614 Hunting Park Drive 21801 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 127 Yes 2 □ No If Yes, Give Year or Dates: Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. t ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 Army 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry oe filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Probation Dept. Supervisor Juvenile Court 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be be and Mental Herbert James Deggendorf Aurelia Dugan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 i Genevieve Jensen Deggendorf/wife 614 Hunting Park Dr. Salisbury, MD 21801

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State Department of himportent: If ite any injury or of once. 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem 4/28/05 Arlington, Va 21. Signature of Funeral Service Licena Holloway Funeral Home Professional Association Muto 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 DAYS Immediate Cause (Final disease or condition resulting in death) meumonia /Medical Dué to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No. 3 Probably 4 Unknown anease 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes 2 No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) o 27. Many of Death the funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Records, P.O. Vital Division To the Hospital within 24 hours a To the Funeral Completely filled in

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10 m

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

odney a. W. mud.

29c. License number

1 🖰 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D 15384

29d. Date signed (Month, Day, Year) APRIL 15, 2005

120

21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1346 S. PIVISION ST. SALISBURY RODNEY WENRICH

31. Date filed (Month, Day, Year) APR 1 9 2005 32. Registrar's Signature

Registrar

	1 - For State Registrar	State of Man		artment of Hertificate of C		Mental Hy	giene (	)5	14825
Physician	Decedent's Name (First, Middle, Landson L					2. Date of De	aath Day	Yeer	3. Time of Death
/Medical	Ida Mae Deshield					04	15	05	0239 1
Examiner	4a. Facility Name (If not institution, gir	ve street and number)	1 Auto	4b. City, Town, or	Location of Death	•	4c. County	of Death	
	5. Social Security Number 6.	Sex 7. Age (1	In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	rth /	/	
Funeral Director		·	84 Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, Da Jan 23	1921	Coui	place (State or Foreign htry) MD
yland	10a. State 10b. County	10	Oc. City, Town or Lo	ocation				1	0d. Inside City Limits
a-f st	MD Wicomi	.co	Salisbur	У					1 X Yes 2 No
1215-0036 within 72 hours after death with the Maryland one one one of them returned; or items 23e or 28e-1 show the Marical Examiner must be notified at ompleted by Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of		ntry?
6 after death wor itams 23a miner must be	708 Booth Street			2180				s.	
er de Itams DELT	11. Marital Status	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ Xio	er in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (S) n, Mexican, Puert	pecify Yes or No Rican, etc.)	0-   14. Ra- Bla	ce - Americ ck, White,	ean Indian, etc.
urs aft	1 ☐ Never Married 2 ☐ Married  32 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 █ <b>X</b> No	Specify:		Specia	y: Blac	ck
215-0036 tithin 72 hours atl se "natural; or Madical Exami	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	tion		16b. Kind of B	usiness/In	dustry
Phin 72	(Specify only highest gi	rade completed)  College (1-4or 5+)	(Give	kind of work done do DO NOT use retired)	uring most of wor	king			
and 21215-0036  be filed within 72 hours after death with the Marylan hall Hygiene.  so other then "natural; or itams 23a or 28a-1 show event, the Madical Examiner must be notified at Be Completed by Funeral Director	12			Linework					facturer
be file tal Hy d oth even	17. Father's Name (First, Middle, Las	t)			18. Mother's Nam		, Maiden Sumai	ne)	
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than any injury or other traumatic event, Itam once.  To Be Compl	Charles Brown				Ethel P				
Mar 12 sh 12 sh 18 m 18 m 18 m	19a. Informant's Name/Relationship			ing Address (Street a					Code)
e, N 1 and 1 eaith 1 eaith 1 eaith 1 thar tr	Lawrence E. Wrigh		20b. Place of Disp	Shawnee Av	venue, S	alisbur Date	y, MD 2 20c. Location		own State
Pages nent of the try or o	1 XBurial 2 ☐ Cremation 3	☐Removal from State	cemetery, cre	matory or other place				1	
Baltimore, sernit. Pages 1 ar Department of Hea mportant: If item iny injury or otha unce.	`4 □Donation 5 □ Other (Spec	My) ensee		11 Memory S 2. Name and Address		/2005	Salis	soury	, MD
Balti permit. Departr imports any inju	2/19		L	ewis N. Wa	atson Fu				
	23a. Part1. Enter the disease, or cor	nolications that caused th	e death. Do not en	618 West I iter the mode of dying	Rd Sal	Soury, or respiratory a	MD 2180	)1	Approximate
Physician	shock, or heart failure. List only Immediate Cause (Final	y one cause on each line.	in Ne	s o Natary	for 1	we			Onset and Death
/Medical	disease or condition resulting in death)	Due to (or as a c	consequence of):	Spivalag	- jar				sars
Examiner	Convention link and distance	, Straige	lated	unsili	ical h	2/MG			4celes
ner de	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence of):						
8760, sate be executed hysician and the burial-transit	Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):						
8760, rate be exphysician at the burial		Due to (or as a c	consequence or).						
6876( ifficate be g physicia as the bun edical	•	d							
ords, P.O. Box 68760, requires that the death certificate be executed reen signed by the attending physician and hould be detached for use as the burial-transit sted by Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy				23d Da	ate of deliv	erv
P.O. Box nat the death cert dby the attending letached for use.	in the past 12 months?	1□Live birth 2   4□Pregnant at tin		□Ectopic pregnancy □ Other (s <i>pecify</i> )			1	onth	Day Year
p.O. I that the de the by the a detached for detached fy Physic	1 Yes 2 No 9 Unknown	9□ Unknown							
IS, Presthal		contributing to death but	not resulting in the o	underlying cause give	en in Part I.	23e. Did	tobacco use con	tribute to t	ne cause of death?
Cord: w require been sig should b	atrial Trov	illation				1 🗆	Yes 2 No	3 Prot	oably 4 Dunknown
Il Record The law requir ate has been s page 2 should						24a. Was			opsy findings available impletion of cause of
The The page							ormed? 2 No	death?	2 No
f Vital Re sysician: The sis certificate hadirector, page	25. Was case referred to medical				26. Place of Dea	th (Check only	one)		
0 5 5 5	1 ☐ Yes 2 No	Hospital:			4   Nursing H		idence 6 Ot		<b>'</b> y)
on of ding Phy. After thi funeral tion; T	27. Manner of Death  1. Natural 5 Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time (	Work		28d. Describe	how injury occu	rred	
Division ( tal or Attanding F rs after death. al Director: After t ed in by the funers Certification;	2 Accident investigati 3 Suicide 6 Could not	be One Place of Jaium	. At home form of		res 2 □No	28f Location	Stroot and Num	har or Pur	al Route Number,
or At or At after Dirac in by	4 Homicide determine		/ - At home, farm, si (Specify)	treet, factory, office			wn, State)	ber or Hura	al Houte Number,
spital nours a naral L		Physician: To the best of	mv knowledge, dea	th occurred at the tim	e date and place	and due to the	cause(s) and m	anner as s	tated.
공유교 등	(Check only 2 Medical Exe	emind: On the basis of eand manner state	xamination and/or in	nvestigation, in my op	pinion, death occu	rred at the time	, date and place,	and due t	the cause(s)
within 2 To the comple	29b. Signature and title of centries	1 -		29c. License	number		29d. Date signe	ed (Month,	Day, Year)
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	Mx bull	WULLOOV	1 11/11	/ / /	1700			' [	)
300	30. Name and address of person who	completed cause of dea	ith (Item 23a) (Type	, Print)	1700	V	1) 45	~ (	100
3 <sub>M</sub>	30. Name and address of derson who	Cerrique,	th (Item 23a) (Type	parle	verille	¥, S-	ite AD	$\alpha_{j}$ s	a listary uni

DHMH 17 Rev 1/2001

			1 - For State Registrer		Maryland / De C	partment of ertificate of			Reg. No	05   4826
	Physici	an	Decedent's Name (First, Middle, L Frances Louise ]	,				2. Date of D	Day	Year 3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, gi		or)	4b. City, Town,	or Location of	Death April		005 2130 PM
			Washington Coun	ty Hospita	1		erstown		Wash	ington
	Funeral Director			Sex 7. A 1 □ M 2 1 F	Age (In yrs. last birthda 88 Yrs	Months Days		Min. 8. Date of B	irth Pay, Year) 9, 1916	9. Birthplace (State or Foreign Country) Maryland
	yland		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Be-f st	ctor	Maryland Washi	ngton	Hage	erstown				1 XYes 2 No
	ath with the 23s or 2	Funeral Director	10e. Street and Number 206 Sunbrook Lar	ne		10f. Zip Code 217	42		10g. Citizen of USA	What Country?
920	72 hours after death with the Maryland natural', or Itams 23a or 28e-f show Acal Exam nor must be motified at		11. Marital Status  1 □ Never Married 2X Married  3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	s? ③ No	3. Was Decedent of If Yes, specify Cul		n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Rai Bla Specii	ce - American Indian, ck, White, etc. fy: white
Maryland 21215-0036	within ane. than "	Completed by	15. Decedent's Elementary/Secondary (0-12)		(G.	cedent's Usual Occu ive kind of work done b. DO NOT use retire homemaker	e during most o ed)	f working		own home
DQ 5	Hyg Than	Be C	17. Father's Name (First, Middle, Las			110 Memerica	18. Mother's	Name (First, Middle	e, Maiden Sumai	
ylar		ToE	Amos Carpenter					y Klinefel		
Mar	12 a 7 15 a 15 a 15 a 15 a 15 a 15 a 15 a		19a. Informant's Name/Relationship  John A. Ditmer			ailing Address (Stree				, State, Zip Code) 1and 21742
	1 ar Hea Brm thai		20a. Method of Disposition		20b. Place of Dis	sposition (Name of trematory or other pla	1	Date		City or Town, State
Baltimore,	it. Pages artment of h ortant: If Its njury or of		1 🔀 Burial 2 □ Cremation 3 I  14 □ Donation 5 □ Other (Spec			awn Mem.		/26/05	Hagers	town, Maryland
Balt	pernit. Pag Department Important: any njury o		21. Signature of Funeral Service Lice	ensee MMa	nau	22. Name and Addr		MINNICH		HOME Maryland 21740
ĺ			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that cause	ed the death. Do not					Approximate
The second second	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to or a	ine.	Since (	Lowi	ende	Jun Jun	Interval Between Onset and Death
8760,	/Medical Examiner	Ilcal Examiner	Immediate Cause (Final disease or condition	a. Due to or a	ine.	Smell.	Lowe	enland In A	Tura tro	Interval Between
.O. Box 68760,	death certificate be executed  was a strength of the print of the prin	edical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom	is a consequence of):  is a consequence of):  is a consequence of):  the of pregnancy  2  Fetal death at time of death	3 Ectopic pregnanc	Lowe	ente In A	23d. Da	Interval Between
s, P.O. Box 6	es that the death certificate be executed  was gned by the attending physician and be detached for use as the burial-transit	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	a. Due to or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	ine.  Is a consequence of):  Is a consequence of):  Is a consequence of):  Is a consequence of):  Is a consequence of):  Is a consequence of):	3   Ectopic pregnanc	Lowe	enda I f A A	23d. Da	Interval Between Onset and Death
s, P.O. Box 6	The law requires that the death certificate be executed at the law requires that the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	ine.  Is a consequence of):  Is a consequence of):  Is a consequence of):  Is a consequence of):  Is a consequence of):  Is a consequence of):	3   Ectopic pregnanc	Lowe	23e. Did 1   24a. Was auto	23d. Da Mc tobacco use cont Yes No s an psy psy pometri	Interval Between Onset and Death To Set
Vital Records, P.O. Box 6	The law requires that the death certificate be executed at the law requires that the attending physician and page 2 should be detached for use as the burial-transit	o Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due ty or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown contributing to death	ine.  Is a consequence of):  Is a consequence of):  Is a consequence of):  It e of pregnancy  2   Fetal death  at time of death  but not resulting in the	3   Ectopic pregnance   Other (specify)	ey  ven in Part I.  26. Place of	23e. Did 1   24a. Was auto perfit   1   Yes	23d. Da Mc tobacco use cont Yes No s an 24b. oone 2000	Interval Between Onset and Death Onset and Dea
of Vital Records, P.O. Box 6	ding Physician: The law requires that the death certificate be executed by the attention physician and tuneral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due ty or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown contributing to death Hospital: 1 Inpat 28a. Date of In (Month, D	ine.  Is a consequence of):  Is a consequence of):  Is a consequence of):  Is a consequence of):  Is a consequence of):  Is a consequence of):  It i	3   Ectopic pregnance 5   Other (specify)   e underlying cause given the control of the control	ey  ven in Part I.  26. Place of ther: 4   Nursii	23e. Did 1   24a. Was autroper   1   per   1   Death (Check only on Home 5   Res   28d. Describe	23d. Da Mc tobacco use cont Yes No s an 24b. oone 2000	Interval Between Onset and Deathy  To July  te of delivery onth Day Year  cribute to the cause of death?  3 Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
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Division of Vital Records, P.O. Box 6	To the Hospitel or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification; To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to or a b. Due to or a c. Due to (or a d. Due to (or a d. Due to (or a d. Pregnant 4 Pregnant 23c. If yes, outcom 1 Live birth 4 Pregnant 29 Unknown contributing to death 28a. Date of In (Month, D) be 28e. Place of In building, e completed cause of 32. Regis	is a consequence of):  is a consequence of):	3   Ectopic pregnance 5   Other (specify)   e underlying cause give ient 3   DOA   Other y	26. Place of ther: 4 \( \text{Nursing variance} \) Yes 2 \( \text{No opinion, death of se number} \)	23e. Did  1 24a. Was autoper 1 Yes Death (Check only ng Home 5 Res 28d. Describe 28f. Location City or To	23d. Da Mo  tobacco use cont Yes No s an 24b. psy poy oon idence 6 Oth how injury occur  (Street and Numb wn, State)  cause(s) and ma date and place, 29d. Date signe	Interval Between Onset and Deathy  To July  Ite of delivery onth Day Year  Intibute to the cause of death?  3 Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  Iter (Specify)  Iter or Rural Route Number,  Inner as stated,  and due to the cause(s)

**ORIGINAL** 

DHMH 17 Rev 1/2001

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ELINDS

		_	1 - State Registrar	Maryland / Depa	artment of F		F	Reg. No.200	5   4828
ı	Physicia	an	Decedent's Name (First, Middle, Last)     Mamie	Davenport	<b>-</b>		2. Date of Dea Month April 14,	Day Ye	3. Time of Death 12:50Р м
>	/Medic Examin		4a. Facility Name (If not institution, give street and number Charles County Nursing Home		4b. City, Town, o	r Location of [		4c. County of D	eath
	Funeral Director			Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Birtl Min February 2	/, Year)	Birthplace (State or Foreign Country) Orgla
	Aaryland f show	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince George's	10c. City, Town or Lo Accokeek	ocation				10d. Inside City Limits 1 ☐ Yes 2XXNo
	with the Part of 28a-	Direct	10e. Street and Number 902 Brook Street		10f. Zip Code 2060	7		10g. Citizen of What	Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Exercit at Least to Indifficult once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Deceder Armed Force: 1 Yes, Give 1 Yes, Give 2 Year or Dates	s? E No			1? (Specify Yes or No- Puerto Rican, etc.)	14. Race - A Black, W	merican Indian, /hite, etc. Black
Baltimore, Maryland 21215-0036	within 72 hou ane. than "natura a Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-40)	(Give	dent's Usual Occup kind of work done DO NOT use retired letologist	during most o d)	f working	16b. Kind of Busine Self Empl	
land 2	should be filed of and Mental Hygies marked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Last)	reen		18. Mother's	s Name (First, Middle, Beatrice [	Maiden Sumame) Jnknown	
Mary	is 1 and 2 sho if Health and P item 27 is ma other trauma		19a. Informant's Name/Relationship (Type, Print) Felton Cameron / Son				or Rural Route Numbe k, Maryland	r, City or Town, Stat 20607	e, Zip Code)
nore,	ages 1 a ant of Hea art: If item y or othe	Ì	20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 █ Removal from Stat  4 □ Donatio  5 □ Other (Specify)	ө	matory or other plac	1/.	Date /25/05	20c. Location - City	
Baltir	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee	Evergræn	2. Name and Addre	ss of Facility	eorge P. Kala Oxon Hill, N	Detroit.M as Funeral H Marvland 20	Home P.A.
	Pnysician		23a. Part 1. Enter the disease, or completations that caus shock, or heart failure. List only see cause on each Immediate Cause (Final disease or condition resulting in death)		ter the mode of dyin	g, such as ca	rdiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner	-a	Due to (or a	as a consequence of):					
8760,	death certificate be executed e attending physician and of for use as the burial-transit	al Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or a Due t	as a consequence of);					
9	ertificate ling physi ie as the l	Medica	IF FEMALE:						
P.O. Box	the y th	Physician/Medical		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
	n requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause giv	en in Part I.			e to the cause of death?  ] Probably 4  Unknown
of Vital Records,	The law ate has b page 2 sl	Completed					24a. Was a autop perfor 1 \( \text{ Yes} \)	sy prior med? death	autopsy findings available to completion of cause of 1? fes 2 \(\sumbolea\) No
Zi.	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpa	itient 2 ER/Outpatie	nt 3 DOA Oth		f Death (Check only or ing Home 5 ☐ Resid		Specify)
ion of	ding h. After fune	ertification; T	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		f 28c. Injur Wor	y at	28d. Describe h	ow injury occurred	,
Division	al or Attendes safter death	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building,	Injury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tow		Rural Route Number,
	To the Hospital or Atteni within 24 hours after deatl To the Funeral Director: completely filled in by the	edicai (	29a. Certifier (Check only one)  1 Certifying Physician: To the beside and manner.	of examination and/or in					
	To the P within 24 To the F complete	M	29b. Signature and title of certifier  Mahi Math	- M =	29c. Licens	e number 522		29d. Date signed ( $M$	
	(6)		30. Name and address of person who completed cause of Nalin Mathur MD 10 St.	f death (Item 23a) (Type, Patricks Drive		Maryland	1 20603		
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 9 2005	strar's Signature	B				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 1733 PM MARIALL ALE KESHELLE APRIL 12 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** OUNS HOPKINS HOSPITAL BALTIMONE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months, Days Hours Min. April. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign Country) Maryland **Funeral** 6,1995 Months 1 ☐ M 2√F F 10 Director 219-43-1249 Usual Residence of Decedent the Maryland **Works** 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or itema 23e or 28e-f ehov the Medical Examinar must be notified at Anne Arundel 1 XYes 2 No Director MD Curtis Bay 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21226 U.S.A. 1607 Church Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examina 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3rd Student Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Christine Clark Mark Daley 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1607 Church St., Curtis Bay, MD 21226 Christine Daley (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State b 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from-State Gate of Heaven Cem 4/19/05 ' 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signat of Funeral Service Licens 22. Name and Address of Facility Snowden Funeral Home, P.A. 346 N. Wash. St., Rockville, MD 20850 u 2da. Part 1. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearly failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician NTRACRANIAL PULTENSION MONTIL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Tumon WAIN Sequentially list conditions, it as y, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner certificate be executed as the burial-transit resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant The law requires that the death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No : After this certifica e funeral director, r To the Hospitei or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pendina within 24 hours after death. To the Funeral Director; A М 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Fune Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)005565 4PML 12, 2005 30. ame and address of person who completed cause of death (Item 23a) (Type, Print) SCHMATT. BACTIMONE MD 600 NONTH WOL LAWRENCE 31. Date filed (Month, Day, Year)
APR 18 32. Segistrar's Signature State 2005 Registrar

			1 - For State Registrar	State of Ma	ryland / Depa		lealth and N		9	5 11.020
			1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physic		Jesse Dow	nev.	Day			Month ()4	Day Yea	12:55 P M
	/Medi Examir		4a. Facility Name (If not institution, give s	street and number)	7	4b. City, Town, or	Location of Death	1	4c. County of De	
	LAdiiii	·	Lorien	,		had 1	was aux		Carro	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		
	Director		212-14-7359 1E	M 2□F	90 Yrs.	Months Days	Hours Min.	June 30,	9ar)	Birthplace (State or Foreign Country)  aryland
	ъ		Usual Residence of Decedent			<u> </u>	J	Julie 30;	1/14   110	arytand
	ylan		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mai	į	Maryland Carroll		Mount	Airy				1 X Yes 2 □ No
	r 28¢	irec	10e. Street and Number	•		10f. Zip Code		10g	. Citizen of What	Country?
	30 o	by Funeral Director	705 Midway Avenu	e		217	771		United	States
	death ms 2	era		2. Was Decedent Ev	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-		merican Indian.
(0	r ite	Ē	1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☐ Yes 2 X No				Rican, etc.)	Black, Wi	
03	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify:	White
21215-0036	72 hours after death with the Maryland natural', or items 23e or 28e-f show Jisal Exant her must be a diffied at	Completed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation	. 16	b. Kind of Busines	ss/Industry
21	within 7 ene. then "r	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	(GIVe	kind of work done of DO NOT use retired	during most of work f)	ang		
21	d wit	no.	12			rpenter			Constru	ction
	be filed ital Hygie d other event, II	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Ma.	den Sumame)	
Maryland	Aenta Aenta rked tic e	To	Jesse Downey D	ay			Rena	May Murr	av	
ary	should ind Men a marke umatic		19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Maili	ng Address (Street a		al Route Number, C		, Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menia! Hygiene. Importent: if item 27 ia marked other then "natural", or items 23e or 28e-f show may injury or other treumatic event, the Modical Exprit is truntled in 2006.		David Day / son		5305	Pommel Dr	rive Mt.	Airy, Ma	rvland 2	1771
ē,	s 1 a if He item othe		20a. Method of Disposition		20b. Place of Dispo cemetery, crei				c. Location - City	
Baltimore,	Pages nent of I nnt; if it		1 ☐ Burial 2 【Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Frederick		Apri	1 18, 2005 Fr		
Ē	artme artmo orter injur		21. Signature of Fuperal Service License	10		2. Name and Addres				Maryland
Ba	permit. Departr importe any inju		10017	2			DL	auffer Fu	neral Ho	mes, P.A. yland 21771
			23a, Part1. Enter the disease or compli	cations that caused the						Approximate
			23a. Part1. Enter the disease) or compli- shock, or heart failure. List only or Immediate Cause (Final	e cause on each line	-1 +	0-1	s Co c de	7)	,	Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	Athero/	sclevolco	Cardio	Vincen	~ Dig	ease	
7	Examiner			Due to (or as a	consequence of):	0 0-	11.00			
		<u>_</u>	Sequentially list conditions,	Chron	c Vana	e gai	TWU.			
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence or):					
	and and I-trar	Examiner	that initiated events resulting in death) Last		consequence of):					
8760,	ate be executed obysician and the burial-transit			000 10 (0) 43 4	consequence or).					
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical								1
× 6	leath certifica attending ph I for use as th	Med	IF FEMALE:							1
Вох	ath c ttenc or us	ian/	23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of 1☐Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date of d Month	lelivery Day Year
0.	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at til 9□Unknown	me of death 5	Other (specify)		·	William	Day real
P.(	that the de led by the a detached t	Physician/M	W.W.					1	1	
Ś	res tha signed be det	by	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause give	en in Part I.			to the cause of death?
Records,	w requir been si should	Completed						1 Tes	2 ∐ No 3 ∏ I	Probably 4 Unknown
ec	hasbu	ple						24a. Was an autopsy	24b. Were	autopsy findings available completion of cause of
<u>a</u>	The page	on						performed	i? death?	?
Vital	ician: Th certificate rector, pag	Bec	25. Was case referred to medical				26. Place of Deati	h Check onl one		2010
>	Phyaician: this certifica ral director, p	To	examiner?	ospital: 1  Inpatient	2 ER/Outpatien	t 3 DOA Othe		me 5 Residence	e 6 □Other (Sc	pecify)
J Of	Jing Ph I. After th funeral		27. Manner of Death	28a. Date of Injury (Month, Day 1	Year) 28b. Time of	28c. Injury Work		28d. Describe how i		"
0	ath. r: After e funer	atic	1 Natural 5 ☐ Pending investigation	(Monny, Day	roary injury		res 2 □No			
Division	or Attenuter deat Director: in by the	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	- At home, farm, str	eet, factory, office		28f. Location (Stree	t and Number or I	Rural Route Number,
Ō	s after	Certification:	4 Li Nomolo	building, etc.	(Specify)			City or Town, S	ate)	
	hour hour mere y fille		29a. Certifier 1 Certifying Phys	ician: To the best of	my knowledge, death	n occurred at the tim	e, date and place,	and due to the caus	e(s) and manner :	as stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	(Check only 2 Medical Examin one)	er: On the basis of e and manner state	xamination and/or inv	estigation, in my op	inion, death occurr	ed at the time, date	and place, and du	ue to the cause(s)
	To the withing To the Comp	ž	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Mor	nth, Day, Year)
			> Eame				3064)	A	pril 1:	12005
	9		30. Name and address of person who con	npleted cause of dea	th (Item 23a) (Type.	Print)	11	1 0	11	1 12
			Bonnech Schal		1-109 B	ackRive	NECK K	oad Ba	ItTme V	12005 1aylad 21724
	Sta	te	31 Date filed (Month, Day, Year)		s Signature	A N .				
	Registr	ar	APR 1 9 2	บบร	the St. J.					

			For State Registrar	State of Maryla		artment of I		F	Reg. No. 20 (	)5   [483]
	Physici	an	Decedent's Name (First, Middle, Last)     RICHARD			DONOHOE		2. Date of Dea Month APRIL		ear 0130 M
ı	/Medic Examir		4a. Facility Name (If not institution, give s 23510 SANS SOUCI D			4b. City, Town,	or Location of Death		4c. County of	Death
	Funeral		5. Social Security Number 6. Sex		s. last birthday)	MC DAN	If Under 24 Hrs.	8. Date of Birt	TALBO	Birtholace (State or Foreign
	Director		139-14-7969	M 2□F 87	7 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da June	9,1917 V	VashingtonDC
	yland wor		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
	Ba-fal	ector	MD Talbot	=	Mc Da				10. 0	1 ☐ Yes 2 🛣 No
	3a or 2	Dir	10e. Street and Number 23510 Sans Sou	ıci Drive		10f. Zip Code 216	47		10g. Citizen of Wha	at Country?
36	rs after death I', or Itema 2 xaminar mu	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 □ No If Yes, Give Λ. Year or Dates:		Was Decedent of I f Yes, specify Cub 1  Yes 2  No	Hispanic Origin? (Span, Mexican, Puert Specify:	pecify Yes or No- po Rican, etc.)		American Indian, White, etc. white
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itema 23a or 28a-f ahow any Injury or other traumatic event, the Medical Examinar must be notified at ance.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give	dent's Usual Occup kind of work done DO NDT use retire SINESSM	during most of wor ad)	king	16b. Kind of Busin Constru Real Es	iction/
yland	ould be file Mental Hy arked other	To Be C	17. Father's Name (First, Middle, Last) James Aloysius				Mary F	. Raffe		
Mar	id 2 should be and stream.	0.5	19a. Informant's Name/Relationship (Type Virginia Donoho	oe, Print) oe/Wife	19b. Mailir P.O.	Box 80	8, St.	ral Route Numbe Michae]	r, City or Town, Sta Ls, MD 2	ate, <i>Zip Cod</i> e) 21663
Baltimore,	Pages 1 ar nent of Hea int: if item 3		20a. Method of Disposition  1 Burial 2X Cremation 3 R  4 Donation 5 Other (Specify)	emoval from State	cemetery, crer	sition (Name of natory or other pla e1d-Ech	o1s 4/1	Date 8/05 (	20c. Location - Cit Charlott	ty or Town, State
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service License	chel M0094	1000				AL HOME,	
	Physician /Medical Examiner	her	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to immediate	Due to (or as a conse	hcime	er the mode of dyi		or respiratory ar	rest,	Approximate Interval Between Onset and Death
68760,	Attanding Physician: The law requires that the death certificate be executed rideath.  sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
P.O. Box	the death certific y the attending pl ched for use as I	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnand Other (specify)	y		23d. Date o Month	
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions con Uremia Diwe	tributing to death but not re		nderlying cause gr	ven in Part I.			ute to the cause of death?
al Records,	The law recate has be page 2 sho	Completed						24a. Was autop perfor 1 Yes	rmped? prio	re autopsy findings available ir to completion of cause of th? Yes 2 \sumbox No
Zit:	sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	☐ ER/Outpatier	it 3□ DOA Ot	26. Place of Dea her: 4 Nursing H	th (Check only o	ne)	(Specify)
Division of Vital	To the Hospital or Attanding Physician: The la within 24 hours after death. To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2	atlon; To	27. Manner of De th  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		-	now injury occurred	Зреспу)
Divis	To the Hospital or Attanowithin 24 hours after death To the Funeral Diractor: completely filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		eet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	To the Hospital or within 24 hours affect To the Funeral Diraccompletely filled in h	Medical		sician: To the best of my known.  Ter: On the basis of examination and manner stated.						
	To the within To the comple	Me	29b. Signature and title of certifier	/	/	29c. Licen	se number		29d. Date signed (M	Month, Day, Year)
			ATT	56			+7492		4/10	1205
1	RIN		30. Name and address of person who co Jeffery T. Dent	mpleted cause of death (Ite			ive For	eton MD	21601	
	Sta Regist		31. Date filed (Month, Day, Year)  APR 1 9 20	32. Resistrar's Sign	nature			المناخ المناسبة	21001	

	, <b>*</b>	•	For State Registrar	State o	of Marylai		artment rtificate				lental Hy	giene Reg. No.	05	14832
		144	1. Decedent's Name (First, Middle	e, Last)							2. Date of De	eath Day	Year	3. Time of Death
	Physicia /Medic			James	Day, J	r.					APRIL		2005	2:45 p <sup>M</sup>
).	Examin		4a. Facility Name (If not institution	n, give street and nu	ım <i>ber)</i>		4b. City, T	own, or	Location	of Death			nty of Death	
No.	10 m		VA MARYLAND						POIN If Under		0.0	CEC		
	Funeral		5. Social Security Number 230-22-3919	6. Sex 1⊠M 2□ F	7. Age (In yrs 81	i. last birthday Yrs.	If Under 1	Days	Hours	Min.	(Month, Da	th 19, Year) .0,1923	9. Birth Cou V	place (State or Foreign Intry) LYginia
	Director		Usual Residence of Decedent		01						0 4110	,		
	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "neturel", or items 23c or 28e-f show event, If a Modical Examination that he collided at	tor	10a. State District of Columbia		10c. C	ity, Town or L		lash:	ingto	n			i	10d. Inside City Limits 1∑Yes 2 ☐ No
	r 286	rec	10e. Street and Number				10f. Zip (	Code				10g. Citizen	of What Cou	intry?
	h with	a D	1025 Euclid	Street, N	N			20	0001				U.S.F	4.
	ems	iner	11, Marital Status	12. Was Dec Armed F	cedent Ever in torces?	U.S. 13.	Was Decede	ent of Hi	ispanic Ori n, Mexicar	gin? (Sp	ecify Yes or No Rican, etc.)	)- 14. F	lace - Ameri	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or items 23s or 28e-f show any injury or other treumetic event. If a Mouted Examination with the notified at 200s.	by Funeral Director	1 X Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	ried 1 XYes if Yes, G Year or I	2 □ No ive Dates: <b>1</b> 945		1 🗆 Yes 2		Specify:			Spe	c <i>ify:</i> E	Black
21215-0036	72 hou	Completed	15. Deceder	nt's Education est grade completed	)	16a. Dece	edent's Usual	Occupa	ation during mos	t of work	ina	16b. Kind of	Business/Ir	ndustry
21	uthin ne.	mple	Elementary/Secondary (0-12)	College	(1-4or 5+)	life.	NOT use						Conat	ation
2	iled w lygier her ti	S	unknown  17. Father's Name (First, Middle,	unkno	WII		Cement	. F1.			e (First, Middle	Maiden Sur		ruction
Maryland	d be f ental h ced of c evel	To Be		mes Dav					101 1110111	3, 6, 14, 11,		a Brato		
Z Z	should nd Men marke imetic	Ĕ	19a. Informant's Name/Relations			19b. Mai	ing Address	(Street a	and Numbe	er or Run	al Route Numb			p Code)
	alth a 27 is		Steven Weinber	g, Guardi						Was	hingto	n, DC	200	37
ore,	of He of He ff item		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation	3 □Removal from	20b.	Place of Disp cemetery, cre	osition (Nam matory or oti	e of her plac	e)	1	Date	20c. Locatio		
Baltimore,	t. Pag rtment rtent: njury o		*4 ☐ Donation 5 ☐ Other (\$21. Signature of Funeral Service	Specify)	Qua	ntico Na	ational 2. Name and				20/05	Triano	gle, V	irginia
Bal	Depar Impo		21. Signature of Funeral Service	THE	ar Sc		Lee A.	Pa	tters	son 8	Son Francisco	uneral 903 <b>-</b> 076	,	P.A.
3760, M	Physician /Medical Examiner  white private in the p	llcal Examiner	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CHRO Due to  b Due to	ONIC O (or as a conse	equence of):	CTIVE	PU	LMON	IARY	DISE	ASE		Approximate Interval Between Onset and Death UNKNOWN
P.O. Box 68	ath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome of pregi birth 2 □ Fe gnant at time of nown	tal death 3	□Ectopic pre						Date of deliv	very Day Year
	uires that the de signed by the d be detached	by	Part II. Other significant condit	ions contributing to	death but not re	sulting in the	underlying ca	use give	en in Part I			tobacco use c Yes 2 🗆 No		the cause of death?
òro	w requir been s should	etec									24a. Was			opsy findings available
Division of Vital Records,	The lav	Completed									auto		prior to co death?	ompletion of cause of
ita	icien: Th certificate rector, paç	Be C	25. Was case referred to medical examiner?	al					26. Place	e of Deat	h (Check only			
> <	hysic this ce al direc	To E	1 ☐ Yes 2 XNo		Xnpatient 2[				4 (14)	ursing Ho	me 5 Res			ify)
n c	ding Physicien: n. After this certific funeral director,	lon:	27. Manner of Death  1   Natural 5   Pend	''9	e of Injury nth, Day Year)	28b. Time Injury	of 28	3c. Injury Work	yat k? Yes 2. □	No	28d. Describe	how injury occ	curred	
isio	death ctor: / the f	icat	3 Suicide 6 Could		se of Injury - At	home farm s			165 2	140	28f. Location	Street and Nu	mber or Rur	al Route Number,
Σį	r ii te	Certification:	4  Homicide determ	mined 200. Flac build	ding, etc. (Spec	cify)	,	,				wn, State)		
	To the Hospital of within 24 hours at To the Funerel D completely filled it	ledical C	29a. Certifier Certify (Check only one)	ng Physician: To the I Examiner: On the and ma	ne best of my kr basis of examir nner stated.	nowledge, dea nation and/or i	th occurred a nvestigation,	at the tim	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) and date and place	manner as : e, and due !	stated. to the cause(s)
_	To the To the	Me	29b. Signature and title of certifi	er 00	11		29c.	License	e number			29d. Date sig	ned (Month,	Day, Year)
	10		•	5-500	an			D4	2014	1	1	April	8, 20	005
	10 J/h		30. Name and address of person											
	\		SURINDERPAL	SODHI, M	.D., VA	MARY	LAND	HEA	LTH	CAR	E SYS	CEM, PE	RRY I	POINT, MD
	Sta Regist		APR 1 9	2005	Registrar's Sign	nature for	May 1							

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

				State of Ma	ar y rour rour	•			Death		Reg. No.	OE	11000	3
	Dharini		1. Decedent's Name (First, Middle, Last	)						2. Dete of De Month	Dev	Year	3. Time of Death	5
-	Physici /Medio		MARY CATHERINE	FAULDER						APRIL	18 200	05	9:00 AM	1
	Examir	ner	4a Fecility Neme (If not institution, give	·	THE PARTY			1.	4b. City, Town, or				TO I	
	<u>.</u> 6.5.1		JULIA MANOR HEALT  5. Social Security Number 6. Sec		NTER e (in yrs. lest	birthday)	If Under	1 Year	HAGEL If Under 24 Hrs	RSTOWN  8. Date of Bir (Month, De		ASHING 9. Birthola		_
- x-	Funeral Director			]м 2⊠ F	88	Yrs.	Months	Days	Hours Min.	DEC. 2	4, 1916	MARY	ace (State or Foreign ry) YLAND	_
	how a		10a. State 10b. County		10c. City, T	own or Lo	cation			•		10	d. Inside City Limits	
	Ba-f s	Director	MARYLAND WASHIN	GTON					HAGERST	OWN			1⊠Yes 2□No	_
1	ter death with the Maryler thems 23a or 28a-f show ther mant be notified at	급	10e. Street end Number				10f. Zip		24 7 / 0		10g. Citizen of V		у?	
	78 23 78 23	Funeral	333 MILL STREET  11. Maritel Stetus	12. Was Decedent E	Ever in U.S.	13. V	Vas Deced		21740 Iispanic Origin? (S an, Mexican, Puer	Specify Yes or No		.S.A. e - America	n Indian,	_
020	हैं है	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo				an, Mexican, Puèr Specify:	to Rican, etc.)	Specify		tc. ITE	
21215-0020	n /z nours naturali, ndical Exp	<b>g</b>	15. Decedent's Edu		1	6a. Deced	lent's Usua	I Occup	pation	rkina	16b. Kind of B			
21	then r	Completed	(Specify only highest gred Elementery/Secondary (0-12)	College (1-4or 5-	+)	life. D	OO NOT us	e retire	during most of wo	ikiig				
CA 1	be filed withintel Hygiene. Id other than event, the M	S	5 17. Fether's Name (First, Middle, Last)				НО	MEM/	AKER	me (First, Middle		N HOME	<u> </u>	
Maryland	Mantel h	o Be	EZRA DANIEL SUMMER	S EI OOK						ERTRUDE		,0,		
ary	umati	ို	19a. Informant's Name/Relationship (Ty		1	19b. Mailin	g Address	(Street	and Number or R			Stete, Zip (	Code)	_
	and 2 127 is		ROSIE D. SNYDER/DA	UGHTER	2	1538	BLAC	K RO	OCK ROAD	, HAGERS	TOWN, MA	ARYLAN	D 21740	
ore	reges reges renert of Harrit: If item		20a. Method of Disposition 1   Buriel 2 □ Cremetion 3 □ F	lemoval from State	20b. Plece ceme	of Dispos etery, crem	sition (Nem netony or ot	ne of ther plac	ce)	Date	20c. Location -	City or Tow	m, State	
Baltimore,	permit. Feges i and 2 should Department of Haalth and Man Important: If Item 27 is merke any injury or other traumatic once.		4 ☐ Donation 5 ☐ Other (Specify)		BEAV			-		21/05	HAGERST	OWN,	MARYLAND_	_
Ba	Depa impo any i		21. Signature of Fineral Service Iron	PaulM.	. Dean				ss of Facility  L HOME		d Nation			
-	my (4)		23a. Part1 Enter the disease, or o'mpl shock, or heart failure. List only or	Cu				3.5		Boonsbo			21713 Approximate	
P	hysician		shock, or heart failure. List only of	ne cause on each lin	e.								Interval Between Onset and Death	
	/Medical Examiner		Immediate Cause (Final disease or condition	SEVEY.	e le	Enceri	toa						CX	
		10	resulting in death)		Due to (or es	a conseq	uence of):		20	1 (			7	1/3
7	d d ansit	edicai Examiner	Sanuardially list and disease	. Chroni	Due to (or es	a consen	wat U	e	1almay	disen	4	i.	50×	_
oʻ	a axed ien an inal-tr	Exe	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events		- 40 10 (01 00				7			1		
68760,	physicien and sthe bunal-transit	dlca	that initiated events resulting in deeth) Lest	)	Due to (or as	a consequ	uence of):							_
		-		d										
m g	atten	Iciar	Part II. Other eignificent conditions con	stribution to death bu	t not recultin	g in the up	derlying	oueo cin	on in Part I	23h Did	tohacco use co	ntribute to	the cause of death?	,
l Records, P.O. Box	as that the death cert igned by the attendin be datached for use	by Physician/	raith. Other eighnicent conditions cor	ithoung to death bu	t not resultin	g iii trie di	derlying ce	ouse giv	en in raiti.		Yee 2□No		ably 4 □ Unknown	
8	as tria igned be da	by					·			-				
ord	been si should (	Completed									an autopsy med?	avai	e autopsy findings lable prior to apletion of cause	
Rec	has t	E E								1941	nn rawan	of de	eath?	
	flicate or, per	ပိ	25. Was case referred to medical						26 Place of Do	ath (Check only o	7	10	Yes 2□ No	4
	s cert	To Be	evaminor?	lospital:	nt 2 ER/	Outpatien!	t 3□ DO	A Oth	ier: 45 Nursing F			er (Specify)		
vision of Vita	ter thi	Ë	27. Manner of Death 1 ☑Naturei 5 ☐ Pending	28a. Date of Injury (Month, Dey	Year) 28	b. Time of Injury	28	8c. Injur Wor	y et k?		now injury occur			
Sio	leath. tor: Af the fu	catle	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2 □ No	00/ 1	O		David March and	4
i į	offer of the color	Certification:	4 Homicide determined	28e. Place of Inju building, etc.	ry - At home . (Specify)	, farm, stre	et, factory	, office		City or To	Street end Numb vn, Stete)	er or Hurai	Houte Number,	
l legicach et	to the hours effer death.  Within 24 hours effer death.  To the Funeral Director: After this certificate has completely filled in by the funaral director, page 2	edical C	29a. Certifier (Check only)  1 Certifying Physical Examination	sicien: To the best of	f my knowled	dge, death	occurred a	at the tir	ne, date end place	e, and due to the	ceuse(s) and ma	inner es sta	ited.	
1	hin 24 the F	Medi	one)	end manner stet	ted.				e number		29d. Date signed			4
F	2 <b>3</b> 6 8		29b. Signature and title of certifier				250.		52323		4/12	M Contain, D	-y, 1001/	
		-	30. Name end address of person who co		eath (Item 23	e) (Type. F	Print)	-1	1000)		((/0	J		_
51	1-6		Khalid M. Waseem,					На	gerstown	, Maryla	nd 2174	<b>4</b> 2		
*	Sta Registr	_	31. Date filed (Month, Day, Year)  ADD 2.0.20	32. Registra			white							

DHMH 16 Rev 6/95

)			For State Ragistrar	State of Marylan	d / Depa		lealth and M	lental Hy		2005	11,831.
			Decedent's Name (First, Middle, Las	()			Journ	2. Date of De			3. Time of Death
	Physici	an		•				Month	Day	Year	
	/Medic	al	Miguel	Sanchez		Flores		APRIL	14		J.40A.
	Examin	er	4a. Facility Name (If not institution, give	street and number)			Location of Death			County of Deat	h
			Rt.273 and Road 3			SINGERI			CE	CIL	
	Funeral		Social Security Number     6. Se	XM 2DE		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	9. Birt. Co	hplace (State or Foreign untry)
	Director		222-98-256/	62	Yrs.			Dec 8 1	942	Mex	<u>kico</u>
	pu k		Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Lo	cation					10d. Inside City Limits
	aryla eho	<u>-</u>									1 🕅 Yes 2 🗆 No
	Ba-f	ctc		astle W	ilming						
	or 2	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citia	zen of What Co	untry?
	238 151	a	116 N. Franklin			198				Mexico	)
	ema err	Ine	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	- 1	<ol> <li>Race - Ame Black, White</li> </ol>	
98	or it	Y	1 Never Married 2 Married	1 ☐ Yes 2 ☐No If Yes, Give		1 X Yes 2 □ No	Specify: Mex	ican		Specify:	Hispanic
ğ	tiled within 72 hours after death with the Maryland Hygiene. that than "natural", or Itama 23a or 28a-f ehow that the Macical Examinat must be notified at	Completed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:							
21215-0036	72 h	ete	15. Decedent's Ed (Specify only highest grad		16a. Dece (Give	dent's Usual Occupa kind of work done of	ation during most of worki d)	ing	16b. Kir	nd of Business/	Industry
7	ithin be.	idπ	Elementary/Secondary (0-12)	College (1-4or 5+)	_		1)				
N	ygien ygien ygien ygien ygien t	ပ္ပ	6		Groot	ner				rse Trai	iner
힏	d otl	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden .	Sumame)	
<u>X</u>	Men arke	ပ	<u>Feliciano Sanchez</u>	Gaspar			Juana F	lores			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or itema 23a or 28a-f ehow amply injury or other traumatic event, the Modical Examination in the notified at Once.		19a. Informant's Name/Relationship (7	ype, Print)			and Number or Rura				
	and ealth n 27 nar tr		Eladio Sanchez				Avenue				9805
Baltimore,	of H of H it item		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☒	Removal from State	lace of Dispo emetery, crer	sition (Name of natory or other plac	Aprif	<sup>2</sup> 9	Ma va	cation - City or i	Town, State Guerrero,
Ĕ	Pag nent ant: 1 ury c		`4 □Donation 5 □ Other (Specify		npo Sai	nto	2005			Mexic	0.0
alt	permit. Departr Importa		21. Signature of Fineral Service Licen-		22	. Name and Addres	ss of FacilityCorl	eto La	tina	Funera	1 Home
œ	89 5 5 8		Tyell	cy >	<u> </u>	08 N. Uni	ion Street	: Wilm	ingto	on, Dela	aware 19805
			23a. Part Enter the disease, or comp shock, or heart failure. List only	lications that caused the death	n. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	01/1/	1:						Onset and Death
7	/Medical		resulting in death)	a. Due to (or as a conseq.	uence of)	uvis					
	Examiner						W.,		•		
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	uence of):						1.
	uted d ansit	교	Cause (Disease or injury that initiated events							70	
Ć.	exec in an ial-tr	Examiner	resulting in death) Last	Due to (or as a consequence	uence of):						
1760,	ate be executed hysicien and ihe burial-transit	cai		d.							
89	tificat ng phy as th										
Вох	eath certifica attending ph for use as th	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		_			2	3d. Date of deli	very
ă	leath atte	cia	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnancy Other (specify)			- 11	Month	Day 'Year
o.	that the death ted by the atter detached for u	ysi	9 Unknown	9 Unknown					1		
Ω.	The law requires that the death certifica lie has been signed by the attending ph page 2 should be detached for use as t	by Physician/Med	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco us	se contribute to	the cause of death?
ds,	uires sign							1 🗆 Y	es 2[	]No 3□Pro	obably 4 Unknown
00	w requir been si should	lete						24a. Was	20	24h Wara au	topsy findings available
Record	The law cate has page 2	Completed						autop		prior to death?	completion of cause of
	ician: Th certificate rector, pag							1 Yes		1 Yes	2 No
Vital	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		othe	26. Place of Death				
ō	Phys this rat di	<u>۲</u>	1 XYes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatien 28b. Time of	I 3 DOA	4   Nursing Hor	ne 5∐ Resid 28d. Describe h			SCENE
	Attending In death.	ion	1 ☐Natural 5 ☐ Pending	(Month, Day Year)	Injury	Work		roseden	1 1-28	will un	yeu .
<u></u>	ttend death stor: /	ica	3 Suicide 6 □ Could not be	28e. Place of Injury - At ho	ma form str	HRI	1	28f Location (9	Street and	Number or Bu	ral Route Number.
Division	or Attendated after death Director:	Certification:	4 Homicide determined	building, etc. (Specif	1)	oot, radiory, dillos		City or Tow			73 + Road 3
	pital ours arai filled		29a, Certifier 1□ Certifying Phy	vsician: To the best of my kno	wladaa daat		an data and place a	lecel Com	77		atalad
	To the Hospital or Attending I within 24 hours after death.  To the Funaral Director: After completely filled in by the funer	edicai	(Check only 2 Madical Exam	iner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my or	pinion, death occurre	ed at the time, o	date and	place, and due	to the cause(s)
	o the	Me	29b. Signature and title of certifier	and marrier states.		29c. License	e number		29d. Date	signed (Month	n, Day, Year)
	F ≥ F 8		100	11-1.		OCM		1			
			30. Name and address of person who of	completed cause of peath (Item	220) (T ==	Briet)			HLKTI	L 15,200	ע כ
	0		THE DOORE MIK		1 23 <i>4)</i> (1998,	111	Penn Stree	et Bal	timo	re, Mar	yland 21201
	, Sta	te			ture						
	Registr	4	31. Date filed (Month, Day, Year) APR 1 9 2005	32. Registrar's Signa	good						

DHMH 17 Rev 1/2001

	_		1 - For S State Registrar	tate of Maryl		artment rtificate			nd M		iene () (	) 5	14835
	Physici	an	Decedent's Name (First, Middle, Last)	_						2. Date of Death Month	Day	Year	3. Time of Death
	/Medi		Ernest Rorapaugh Fo							Apr.		2005	5:10 p M
7	Examir	ner	4a. Facility Name (If not institution, give stree Chesapeake Hospice			4b. City, To					4c. County		
			5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1		nicum		O Data of Birth			Arundel
и	Funeral Director		217-30-5158 1XM		70 Yrs.		Days	Hours	Min.	8. Date of Birth (Month, Day, Mar. 26	Year) 1935	9. Birthp	lace (State or Foreign try) MD
	ס		Usual Residence of Decedent							1141. 20	, 1555		MD
	e Marylar ie-f show	Director	MD 10b. County Anne Arun		. City, Town or Lo		apol	lis				1	0d. Inside City Limits 1 ☐ Yes 2 🔀 No
	or 28	Dire	10e. Street and Number			10f. Zip C				10	g. Citizen of V	hat Coun	itry?
	ath w	<u>a</u>	318 Locust Avenue				2140					USA	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28e-f show any injury or other treumatic event, I'm Medical Evertiral renal is notified at once.	by Funeral	1 ☐ Never Married 2 ☑ Married 1	Vas Decedent Ever ii krmed Forces? □Yes 2∰No fYes, Give ′ear or Dates:		Was Deceder f Yes, specify 1 ☐ Yes 2		panic Origi , Mexican, Specify:	in? (Spec Puerto F	cify Yes or No- Rican, etc.)		e - Americ k, White, W	
20	72 ho	Completed	15. Decedent's Education (Specify only highest grade control		16a. Deced	dent's Usual (	Occupati	ion	of workin	. 1	6b. Kind of Bu	siness/Inc	lustry
2	hen hen	mp.	Elementary/Secondary (0-12)	College (1-4or 5+)	(	kind of work DO NOT use				9	DD	1	
22	Hygie thert		17. Father's Name (First, Middle, Last)	<u> </u>	Ge.	neral				(27)	ER Fow		Sons
Maryland 21215-0036	ould be     Mental     warked o	To Be	David Fowler					Erne	esti	(First, Middle, M ne Rorap	augh	,	
, Mar	and 2 sh salth and n 27 Is m		19a. Informant's Name/Relationship (Type, I Betty L. Fowler/Wi							Route Number, apolis,			Code)
Baltimore,	Pages 1 ment of He ent: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State	b. Place of Dispo cemetery, cren Metro Cr	natory or othe	ər placə)	A	pr. 20	15, 05'	oc. Location - 1 Baltimo		
Balt	permit. Depart Import any inj	y g	21. Signature of Juneral Service Licensee	4	B 49	altranto 95 Gov	eddræs • Ri	Sons, tchie	P.A Hwy	A. Sever y, Sever	na Parl na Parl	k Fur	neral Home 21146
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ns that caused the deuse on each line.	eath. Do not ente	er the mode o	of dying,	such as ca	ardiac or	respiratory arres	it,		Approximate Interval Between
	Physician	(¢. I	Immediate Cause (Final disease or condition	ineta	Mate	- 6	len	-ce					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):	-							
	Half.	- i	Sequentially list conditions, b.	Due to (or as a pone	en pr	ula	elo	Les					
	uted I ansit	Examiner	Sequentially list conditions, it is a list of the sequential to the sequential cause. Enter Underlying Cause (Disease or injury	Cer	Con 1	1	. 2						
ó	ate be executed hysician and the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):		X.					_	
8760,	ate be hysicii he bu	dlcal	d.										
		Med	IF FEMALE:						-1				
O. Box	the death certifica y the attending ph Iched for use as the	Physician/Me	23b. Was decedent pregnant in the past 12 months?	yes, outcome of prec □Live birth 2 □ Fo □ Pregnant at time o □ Unknown	etal death 3	Ectopic pregr Other (speci					23d. Date Mon		y Day Year
ds, P	as t	ρ	Part II. Other significant conditions contribu	ing to death but not r	resulting in the un	derlying caus	se given	in Part I.					e cause of death?
Record	s been significant should k	olete								24a. Was an	24h W	ere auton	sy findings available
-	i <b>icien</b> : The law certificate has b rector, page 2 sl	Completed								autopsy performe	pr d? de	ior to com ath?	pletion of cause of
Viitai	Physicien: this certifica ral director, p	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospit	al:		•C.D.O.	Othor			Check only one)			Hospice
Division of	Attending Phy if death. sctor: After this by the funeral d	atlon: To	the state of the s	a. 1 Inpatient 2 a. Date of Injury (Month, Day Year)	28b. Time of		Injury at Work?		28	e 5 Residence d. Describe how			House
Divis	tal or Attendi s after death. al Director: A ad in by the fu	Certification:	3 Suicide 6 Could not be determined 28	e. Place of Injury - At building, etc. (Spe	t home, farm, stre	et, factory, of	ffice		28	f. Location (Stree City or Town, S	et a <i>nd Numbei</i> State)	or Rural	Route Number,
	he Hospi in 24 hou he Funer pletely fill	edical	29a. Certifier (Check only one) 1 Certifying Physicier 2 Medical Examiner: (a	: To the best of my k on the basis of exami and manner stated.	nowledge, death nation and/or inve	occurred at the estigation, in	he time, my opini	date and point on, death	olace, an	d due to the caus	se(s) and man	ner as star id due to t	ted. he cause(s)
	To t To t	Σ	29b Signature and title of certifier				cense nu			29d	. Date signed	Month, D	ay, Year)
	1		Curles /t	ani.	(m)	0	53	300	6		4/19	1/0	2.5
			30. Name and address of person who comple				c I		M			4	. / /
	Stat	0 *	31. Date filed (Month, Day, Year)	32. Registrar's Sig	5/59/2	RO	>/6	4//	11	nnapyl	5 Mi	1 2	144
\$ ·	Registra		APR 1 5 200		A A	boute							

			1 - State of Maryland / I		rtment of l tificate of			ene 005	5 14836
	Dharaini		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Yea	3. Time of Death
	Physicia /Medic		Mary Eileen Galvin				April	19 200	5 10:10 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)			or Location of Deat	h	4c. County of D	
			8434 Tusings Way		If Under 1 Year	Boonsboro  If Under 24 Hrs.	O Date of Blate		hington
	Funeral		5. Social Security Number 6. Sex 1 M 3 TVF 7. Age (In yrs. last bi	Yrs.	Months Days		(Month, Day, 1	Year) 9.	Birthplace (State or Foreign Country)
+	Director		015-30-2316 XX 65				May 18,1	939 Ma	ssachusetts
	/land		10a. State 10b. County 10c. City, Tow	vn or Lo	cation			-	10d. Inside City Limits
	Many -feh lied	tor	Maryland Washington	Вс	onsboro				1 ☐ Yes 2 🛣 No
	h the	Directo	10e. Street and Number		10f. Zip Code		10	g. Citizen of What	Country?
	th wit	al D	8434 Tusings Way			21713			USA
	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Was Decedent of f Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puer	pecify Yes or No- to Rican, etc.)		merican Indian, /hite, etc.
99	filed within 72 hours after death with the Maryland Hygiene. Other than "naturelt, or Items 23s or 28s-f show out, the Madical Examiner must be notified at	y F.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give		I□Yes 21X No			Specify:	
Ö	uref.	d by	3 Widowed 4 Divorced Year or Dates:	Deces	dent's Usual Occu	vention	14	6b. Kind of Busine	White
<u> </u>	"nat	Completed	(Specify only highest grade completed)	(Give	kind of work done  OO NOT use retire	during most of wo		ob. Killa of basille	ssamoustry
2	withi ene. then	mc	Elementary/Secondary (0-12) College (1-4or 5+)	Ви	ıc Acci	stant		Educa	tion
0	Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)		10 11001		me (First, Middle, M		1101.
<u></u>	ild be lental ked o	To B	William H. Conley			Cath	erine	Fole	у
Maryland 21215-0036	should by and by		19a. Informant's Name/Relationship (Type, Print) 19	b. Mailin	ng Address (Stree	at and Number or Au	ıral Route Number,	City or Town, Stat	e, Zip Code)
	ss 1 and 2 of Health ar item 27 le						Hagerst		
altimore,	of He of Herican		20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State	of Dispos ery, cren	sition (Name of natory or other pla	ace)	Date 2	0c. Location - City	or Town, State
<u>Ĕ</u>	Pagi ment ent: I		`4 □ Ponation 5 □ Other (Specify) \$miths					mithsbur	g,Maryland
ä	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mendal Hygiene. Importent: If item 27 is marked other then "naturet; or items 23e or 28e-f show emprorient: If item 27 is marked other then "naturet; or items 23e or 28e-f show empty injury or other treumstic event, the Modical Examiner must be notified at once.		21 Sign are of Fundary Servicult /ensee			enereity Ho			04705
<u> </u>	20 = 9 9		MATCH				ue St. Wi		
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ente	er the mode of dy	ring, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition aaa.	he	Se	oil (	Lounce		40 months
	/Medical Examiner		resulting in death)  Due to (or as a consequence	of):	0				
		_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	of):					
	nsit	i	cause. Enter Underlying Cause (Disease or injury	,					W 3
<u>,</u>	al-tra	Examiner	that initiated events c	of):					
8760,	death certificate be executed e attending physician and ind for use as the burial-transit								
9	tificat ig phy as th	Physician/Medical						1	
Box	th cer endir r use	N/us	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal deat	h 3[	Ectopic pregnan	CV		23d. Date of	
		sicia	1 Yes 2 No 4 Pregnant at time of death		Other (specify)	,		Month	Day Year
P.O.	that the ed by th detache	Phy	9 Unknown *	:- Ab	- 4- 4- 5	in Dank!	22a Did tobr	acco uso contribut	e to the cause of death?
	w requires that s been signed k should be deta	by	Part II. Other significant conditions contributing to death but not resulting	នា ៣២ ប	ndenying cause g	iven in Fanti.	1 ☐ Yes	_ \	Probably 4 Dunknown
oro	law requires as been sign 2 should be	eted					-		findings and liable
Vital Records,	W 70 CV	Completed					24a. Was an autopsy perform	prior	autopsy findings available to completion of cause of h?
<u>=</u>	The ate						1 □ Yes 2	No 1 1	Yes 2□No
Ζ	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?  1   Yes   No   Hospital: 1   Inpatient   2   EP/O	Luteration	nt 3 DOA	ther: 4 Nursing F	ath <i>(Check only one</i> Iome 5 <b>X</b> Resider	nce 6 Other (S	Pagaity)
of	Phys rrthis sral di			. Time of			28d. Describe hov		spacity)
ion	Attending I r death. ector: After by the funer	atloi	1 Alatural 5 Pending (Month, Day Year) 2 Accident investigation	Injury		ork? ⊒Yes 2 □No			
Division	or Attendi after death. Director: A	iffica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, the building, etc. (Specify)	larm, str	eet, factory, office	9	28f. Location (Stre City or Town,		r Rural Route Number,
Ö	tel or A	Certification:	January, State (Speeding)						
	Hospitel 24 hours a Funerel tely filled	edical	29a. Certifier (Check only 2 Medical Exeminer: On the basis of examination a						
	the dir the	ledi	one) and manner stated.						
	With To	Σ	29b. Signature and title of certifier	IN	1 29C. Licer	nse number	M 2	d. Date signed (M	00 000
			Mud Munc	NO K	Ch Drien)	N464	10	URIM	au, 2005
5	4-4		30. Name and address of person who completed cause of death (Item 23a)	(Type,	OPAI	CT	Hadan	House	DALIE CW.
	Sta	ate	31. Date filed (Month Pro Year) 2005 32. Rigistrar's Signature			: )	113	الماصادح	1110
3	Regist		MFR & U 2000 Street S.	19	recel		3		

	'State of Maryland' Department of Health and M Certificate of Death	0.0.	
Physician	1. Decedent's Name (First, Middle, Last) William Gene Hartman	2. Date of Death Month	8. Time of Death
/Medical Examiner	4a Fecility Name (If not institution, give street end number)  4b. City, Town, or Lot		
Funeral	Moran Manor Nursing Home Westernpo:  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8 Date of Birth 9 Birth	hplace (State or Foreign
Director	167-26-1308 1 ☐ Min. Days Hours Min. Usual Residence of Decedent	May 8, 1932 W.V.	•
ith the Maryland or 28a-1 show or inciting at	10a. State 10b. County 10c. City, Town or Location MD. Allegany Westernport		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
th with the 23a or 28 MILLY mal	10e. Street end Number 216 Central Ave.  10f. Zip Code 21562	10g. Citizen of What Co United Stat	
ind 21215-0020  be filed within 72 hours after death with the Maryland tal Hygiene. It Hygiene and other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director	11. Mantel Status  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Never Merried 2 ☑ Married  1 □ Never Merried 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 ☑ Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Forces?  1 ☑ Yes 2 □ No Specify:  1 □ Yes 2 ☑ No Specify:	cify Yes or No- lican, etc.)  14. Race - Ame Black, Whit Specify: Whi	e, etc.
Maryland 21215-0020 d 2 should be filed within 72 hours aft th and Mental Hygiene. T le marked other than "natural", or traumatic event, the Medical Exact To Be Completed by F	15. Decedent's Education (Specify only highest grede completed)  Elementary/Secondary (0-12) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Paper Maker	16b. Kind of Business/ Paper Man	
Aaryland 212 2 should be filed with and Mental Hypiene. Is marked other than summatic event, the M		(First, Middle, Maiden Surname) Loretta Fleek	
ore, Marylc es 1 and 2 should of Health and Mer lifem 27 le merke r other traumetic	19a. Informant's Name/Relationship (Type, Print)  June Hartman/ wife  19b. Mailing Address (Street and Number or Rural 216 Central Ave., Wester	•	Zip Code) 21562
Baltimore, bemit. Pages 1 an bepartment of Heal mortant: If Item 2 iny Injury or other		/21/ Cumberland,	·
Baltimo		oal Funeral Home	d 21562
Seculed Physician Physicia	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Ceuse (Final disease or condition resulting in death)  Due to (or as a consequence of):	loma/	Approximate Interval Between Onset and Death
6876( ificata be physicia as the bur	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):		
that the death certified by the attending datached for use y Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute	
cords, requires the been signed should be continued by letted by		24a. Wes an autopsy performed? 24b. V	Were autopsy findings vailable prior to completion of cause of death?
I Relay		\ i	or death?
f Vital Re	25. Wes case referred to medical examiner?  Hospital: Hospital: Other: W		
Division of Vita To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific complataly filled in by the funeral director.  Medical Certification: To Be	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Hom	e 5 Residence 6 Other (Spec 8d. Describe how injury occurred	ify)
Division C tral or Attending P ins after death. ral Director: Attent lied in by the funars Certification:	'3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Ru City or Town, State)	ral Route Number,
n 24 hour ne Funer Funer plataly fill edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, etc. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.		
To the Within 2 To the I complat	29b. Signature and title of Certifier  29c. License number  D 00 /546	3 Power Signed (Month)	9, 2005
	30. Name and address of person who complete cause of death (Item 23a) (Type, Print)  Dr Shin Kim, 90 Main Street, Westernport, MD 21562	The state of the s	
State Registrar	31. Date filed (Month, Pay Year) 3 2005  32. Restrer's Signature		

			For Stete Registrar	State of I	Maryland / Dep	oartment o		and Me	ental Hygien	2005	14838
	Physicia		1. Decedent's Name (First, Middle	, Last)				2	2. Date of Death Month	ay Year	3. Time of Death
	/Medic	al	Sau Ho Soo						pril 12,	2005	3:05 P M
	Examin	er	4a. Facility Name (If not institution,		,		m, or Location o	of Death		c. County of Death	
	Funeral		Washington Adve		ital Age (In yrs. last birthda	y) If Under 1 Yo			. Date of Birth	Montgomen	Cy place (State or Foreign intry)
Н	Director		103-30-7762	1 □ M 2 🙀 F	77 Yrs.	Months Da	ys Hours	Min.	Month, Day, Yea) Aug. 12, 19		intry) g Kong
	put &		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	ocation					10d. Inside City Limits
	Aaryle f sho	ō									1 ☐ Yes 2 ☑ No
	the 1	rect	Maryland Montg  10e. Street and Number	omery	511	ver Spri			10g. C	itizen of What Cou	intry?
	within 72 hours after death with the Maryland one. than "natural", or ffems 23a or 28a-f show the Mudical Examination mail the molified at	ai Di	1201 Caddington	Avenue			20901		US	Δ	
	ems (	ner	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S. 13	. Was Decedent If Yes, specify (	of Hispanic Ori	gin? (Speci	fy Yes or No-	14. Race - Amer Black, White	
36	s after	by Fu	1 Never Married 2 Marri	ed 1 ☐ Yes 2 { If Yes, Give	∑No	1□Yes 2√2		,		Specify:	, 0.0.
21215-0036	hour tural	ed b	3 Widowed 4 Divorced	Year or Date		edent's Usual Oc	cupation		166	Asia Kind of Business/Ir	
15	in 72	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed)	(Gin	re kind of work do DO NOT use re	one during mos	t of working	7	Tana or Businessyn	loustry
212	giene giene er tha	Com	Dementary/Secondary (0°12)	College (1-4d		ountant			Fed	eral Gove	ernment
D	be file tal Hy d oth event	Be (	17. Father's Name (First, Middle, I	_ast)			18. Mothe	er's Name (	First, Middle, Maide	en Sumame)	
<u>\Z</u>	d Men narke	Jo	Chin Chan	i- (T 9/-1)	105.14		Shi	Но		T 0	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and be notified an once.		19a. Informant's Name/Relationsh						Route Number, City		
ē,	Heal Heal tem 2		Yook Lem Soo H 20a. Method of Disposition	oo Husba	20b. Place of Dis	Cadding position (Name o	1	enue Dat		pring, Man Location - City or T	
e E	Page and of the second of the		1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		Fort Lin			\	20052	atus - 1 Ma	
Baltimore,	partm porta y inju		21. Signature of Funeral Service I		107	Cemete	ddress of Facilit	V	3,2005Bre		ryisha
m	90 1 9		John Collin	2 media	5	00 Unive	ersity P	Blvd.	ineral Ho W.,Silve	me, Inc. r Spring,	MD 20901
Н			23a. Part Enter the disease, or shock, or heart failure. List	complications that caus only one cause on each	sed the death. Do not en line.	nter the mode of	dying, such as	cardiac or r	respiratory arrest,		Approximate Interval Between Onset and Death
	≗nysician i		Immediate Cause (Final disease or condition resulting in death)	_ a Acute 1	iyocardial	Infarcti	Lon			9	Onset and Death
	/Medical Examiner		resulting in death)		as a consequence of):						
		e	Sequentially list conditions, if any, leading to immediate	b. Coronat	ry Artery D as a consequence of):	isease					
	uted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
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8760,		dical		d							
9	as as	/Me	IF FEMALE:	23c. If yes, outcor	ne of pregnancy					23d. Date of deliv	
Вох	that the death cer ed by the attendir detached for use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	☐Ectopic pregna				Month	Day Year
o.	0 0 0	hysi	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□ Unknowr	1						
s, P	requires that the een signed by th hould be detache	by P	Part II. Dther significant condition	ns contributing to deat	h but not resulting in the	underlying cause	given in Part I.		23e. Did tobacco	use contribute to t	the cause of death?
Ş	w require been signature								1 🗆 Yes	2 Mg No 3 ☐ Pro	bably 4 ∐Unknown
Vital Record	> -0 -0	Completed							24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
H									performed? 1 ☐ Yes 2 🛣 N	death? lo 1 ☐ Yes	2□ No
Vita	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:					Check only one)		
oţ		. To	1 ☐ Yes 2 🗷 No  27. Manner of Death	28a. Date of I	njury 28b. Time	of 28c. I	njury at		5 Residence		fy)
Division	Attanding I r death. ector: After by the funer	Certification:	1 XNatural 5 ☐ Pending 2 ☐ Accident investig	9	Ďaý Year) Injury		Work? 1 ⊟ Yes 2 ⊟I	No			
Vis	f or Attendi efter death. Director: A	tifica	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 288. Place of	Injury - At home, farm, : etc. (Specify)	street, factory, off	ice	28	f. Location (Street a City or Town, Sta		al Route Number,
٥	ital or A irs efter ral Direc led in by							t			
	To the Hospital or Attent within 24 hours effer deatl To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical 8	Exeminer: On the basi	est of my knowledge, de of examination and/or	ath occurred at th investigation, in n	e time, date an ny opinion, dea	d place, and th occurred	d due to the cause( at the time, date a	s) and manner as s nd place, and due t	stated. o the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title certifie	and manner	stated.	29c. Lic	ense number		29d. D	ate signed (Month,	Day, Year)
	H 3 H 8		//////								
•	(2)		39. Name and address of person	who completed cause of	of death (Item 23a) (Type	e, Print)	403	65	Apr	·i1 12, 2	005
_			Peter J. Sabia		OO Forest	Clar Pag	d #200	Sil <sub>v</sub>	er Sprin	g,MD 209	10
	Sta		31. Date filed (Month, Day, Year)	32. <b>Fø</b> gi	strar's Signature	puli			_		
	Registr	ar	1,,,,	J. A.	THE N P						

		1 - For State Registrar	State of Marylan		rtificate of		MELICAL IT	Reg. N	3 23 20	11.00
Physic	ion	1. Decedent's Name (First, Middle, Last	•				2. Date of D	eath Da	# <del>U U U</del>	3. Time of De
/Medi	cal		EBRON Jr.		Ab Oib Tarra	and an eliminate Day	APKIL	8	20	05 10:15
Exami	ner	4a. Facility Name (If not institution, give Doctors Ho			Lanh	or Location of Dea	1(11		c. County of I	
Funeral		Social Security Number     6. Se		last birthday) Yrs.	If Under 1 Year Months Days					Birthplace (State or Fo
Director		217-32-0408 Usual Residence of Decedent	, 0				000.2	4,1	934	Wash. Do
show	2	10a, State 10b. County		y, Town or Lo						10d. Inside City L 1 ☐ Yes 2
28a-f	rect	MD Anne .	Arundel	المل	aurel			10g. C	itizen of Wha	
23a o	Funeral Director	351 Dameron	South			2072	1		U.S	.A.
items items	nuel	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of F f Yes, specify Cub	lispanic Origin? ( an, Mexican, Pue	Specify Yes or N rto Rican, etc.)	0-		American Indian, Vhite, etc.
/2 hours after death with the Maryland natural; or items 23e or 28e-1 show item Eventrer most be notified at	by	1 Never Married 2 Married 3 Widowed 4X Divorced	1 ☐ Yes <b>②</b> ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐XNo	Specify:			Specify:	Black
natur dicel	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during most of w	orking		Kind of Busin	•
withing then then	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		stodial				.S. F ild L	ish and
al Hyg	BeC	17. Father's Name (First, Middle, Last)		<u> </u>		18. Mother's Na	ame (First, Middle	, Maider	Sumame)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Page 1 and 1	To	Charles W. 1		10h Mailie	ng Address (Street	L	tie M.			To Out 1
ulth and 27 is r r treur		Viola Hebron			Damero:					
Titem of Head		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F		lace of Dispo	sition (Name of natory or other place	ce)	Date	20c. L	ocation - City	or Town, State
trment rtent: i		* 4 □ Donation 5 □ Other (Specify)	2 // St/	// /	t Cemet	-			nover	
Departimon in poor in		21. Signature Funeral Service Lists	The state of the s							Home, P. <i>1</i> MD 20850
		23a Part 1 Enter the disease or compl	- Lucia	7/1						
		shock or heart failure. List only o	lications that caused the death	Do not ent	er the mode of dyir					Approximate
hysician		shock, or heart failure. List only o Immediate Cause (Final disease or condition	lications that caused the death one cause on each line.	l/	er the mode of dyir					
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		1- State of Maryla		artment of Health			iene	14840
Physici		Decedent's Name (First, Middle, Last)     Robert John Ha	awkins			2. Date of Death Month	Day Ye	
/Medic Examin		4a. Facility Name (If not institution, give street and number)  Sacred Heart Hospita		4b. City, Town, or Location Cumberl	and		4c. County of D	ny
Funeral Director		5. Social Security Number 218-24-7939  Cusual Residence of Decedent  6. Sex 1   2 M 2 □ F  7. Age (In yr. 75)  7. Age (In yr. 75)	s. last birthday) Yrs.	If Under 1 Year If Under Months Days Hours		8. Date of Birth (Month, Day, October 3	Year)	Birthplace (State or Foreign Country) Maryland
Maryland f show	ior		City, Town or Lo	Frost	tburg			10d. Inside City Limits 1 ☐ Yes 2 XNo
with the 3a or 28a	i Director	10e. Street and Number 19903 Woodland Road S.W.		10f. Zip Code	32	10	og. Citizen of What	Country? USA
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If the alth and Mental Hygiene.  If the 27 is marked other than "naturel", or Itams 23s or 28s-f show or other treumatic event, the Maryland Erach ar mast be incilled.	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Pes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic C f Yes, specify Cuban, Mexic 1 Yes 2 No Specif		cify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, thite, etc. White
within 72 hours iene than "naturel",	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) 7 0	(Give	dent's Usual Occupation kind of work done during mo OO NOT use retired) Tire		1	6b. Kind of Busine	ss/Industry Labor
ld be filed lental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle, Last) Richard Hawkins		18. Moti	her's Name		<sup>faiden Sumame)</sup> irl Graham	
and 2 should be ealth and Mental m 27 is marked on the treumatic even	-	19a. Informant's Name/Relationship (Type, Print) Peggy Marie Hawkins-Wife	19b. Mailir	ng Address (Street and Num. 19903 Woodlan				
T I J E B		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)		sition (Name of natory or other place) rg Memorial Park		ate 2 April 19, 2005	oc. Location - City Frostbui	or Town, State g, Maryland
permit. Pa Departmen Important any injury		21. Signature of Funeral Service Licensee		Name and Address of Faction in Name and Address of Fac		ome a East N	Main St., Lona	coning, Md. 21539
Physician /Medical Examiner		23a. PartI I nter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	E M	er the mode of dying, such a	as cardiac or	respiratory arre	st,	Approximate Interval Between Ons -t and Death
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertrying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consection of the consection of th						
he death certifica	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not re	esulting in the ur	nderlying cause given in Part	t I.	23e. Did toba		to the cause of death?  Probably 4 □Unknown
vicion: The law rec s certificate has bee director, page 2 shou	Completed	BADERS Mellits				24a. Was an autopsy perform	ed? prior death	autopsy findings available to completion of cause of ?
hysicien this certifii al director	To Be		☐ ER/Outpatien	t 3 DOA Other: 4 D	Nursing Hom		nce 6 Other (S	pecify)
ending P sath. or: After I	Certification:	27. Manner of Death  1 Matural 5 Pending (Month, Day Year)  2 Accident investigation  3 Suicide 6 Could not be	28b. Time of Injury	28c. Injury at Work?  M 1 Tyes 2		8d. Describe hov	w injury occurred	
itel or Att	Certifi	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spec	home, farm, stre	eet, factory, office	21	8f. Location (Stre City or Town,		Rural Route Number,
To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director, After this certificate ha completely filled in by the funeral director, page	fedical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my known one)  2 Medicel Examiner: On the basis of examination and manner stated.		vestigation, in my opinion, de	ath occurre	d at the time, dat	te and place, and o	lue to the cause(s)
To To	2	29b. Signature and title of certifier	<u></u>	29c. License number	875	> 29	d. Date signed (Mo	17,2005
le	to	30. Name and address of person who completed cause of death (Ite  Ar. Robert Wellk 904 Se  31. Date filed (Month, Day, Year)  82. Registrar's Sign	ton D	rive, Cum	berl	and,	Maryla	nd 21502
Sta Registr		APR 1 9 2005	M. A	freels.				

			1 - For State Registrar		State of	f Marylan		artment of tificate of	Health and I f Death		giene Reg. No.	05	14841
	Dhysisi		1. Decedent's Name (First	, Middle, Las	t)					2. Date of De Month	Day	Year	3. Time of Death
	Physici /Medi		LC	UISE	TALIT	HA HO	RINE_			April	17, 20	05	12:05 A M
	Examir	ner	4a. Facility Name (If not in	stitution, give	street and nur	nber)			or Location of Death	ı		ty of Death	
			Frederick M					Freder		0.0		erick	
	Funeral Director		5. Social Security Number 218-38-1413	1	x □M 2 <b>X</b> F	7. Age (In yrs. 91		If Under 1 Yea Months Day		8. Date of Bir (Month, Da August	13,1913	9. Birthp Cour Mary	place (State or Foreign htry) r land
	pue *		Usual Residence of Deceded  10a. State 10b.	dent County		10c. Cit	y, Town or Lo	cation				1	I Od. Inside City Limits
	Maryl 4 ehc	ō	Maryland	Frede	rick		Wa1k	ersville	e			1	¥ Yes 2 □ No
	28a	rect	10e. Street and Number					10f. Zip Code			10g. Citizen of	What Cour	ntry?
	3a o	O is	21 Main	Stre	et			217	93		United	i Sta	ites
	de et	ner	11. Marital Status		12. Was Dece Armed Fo	edent Ever in U.	.S. 13.	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No	)- 14. Ra	ice - Americ	
9	or ite	by Funeral Director	1 Never Married 2	_	1 ☐ Yes If Yes, Giv	2 No		1 ☐ Yes 2 🗹 N		o riioan, oio.,	Speci		Gio.
21215-0036	72 hours after deeth with the Marylend naturel', or items 23a or 28s-f ehow dical Evantiser rust be nutilied at	Q P	3 Widowed 4 □D		Year or Da	ates:	1Co Poss	danda Haval Osa				Whi	
15-	n 72 "nat	Completed	(Specify only		de completed)		(Give	dent's Usual Occ kind of work don DO NOT use retii	upation le during most of wor red)	king	16b. Kind of E	susiness/inc	austry
12	within lene. than "	E O	Elementary/Secondary	(0-12)	College (1	-4or 5+)		ess pro			Retail	stor	:e
	2 should be filed withlr and Mental Hyglene. Is marked other than sumatic event, I've Mi	O I	17. Father's Name (First,	Middle, Last)			1		18. Mother's Nan	ne (First, Middle,	, Maiden Suma	me)	
lan	ould be Mental Marked o	To B	Thomas R	alph	Say1o	r			Dasie	Flora	Еу	ler	
Maryland	2 shot and N Is ma		19a. Informant's Name/Re	alationship (7	ype, Print)		19b. Mailir	ng Address (Stree	et and Number or Ru	ral Route Numbe	er, City or Town	n, State, Zip	Code)
	and 2 selth n 27 I		Luther E. H	orine,	Jr./S			George	St./ Wal				
ore	of He		20a. Method of Disposition  1 ■ Burial 2 □ Crer		Removal from		Place of Dispo cometery, crer	sition (Name of natory or other p		Date	20c. Location		
Ë	Pages ment of lient: If it lury or o		°4 □Donation 5 □ C	ther (Specify	')	G1		emetery		0/2005	Walkers	s <b>vill</b> e	e,Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylen Depertment of Heelth and Mental Hyglene. Importent: If Item 27 Is marked other than "naturel", or Items 23a or 28a-1 ehow any injury or other traumatic event, Tra Medical Examinat results to nullified at once.		21. Signature of Funeral S	Service Licen	Pele	rson	1	. Name and Add	n Ave./ Wa	auffer Ikersvi			
	No.		23a. Part1. Enler the dise	ease, or comp	olications that cone cause on e	aused the deat	h. Do not ent				•		Approximate Interval Between
	Physician /Medical Examiner	ıer	Immedi uf Cause (Final disease or condition resulting in death)  Sequentially list condition is any backing to in recision.	s.	b	or as a conseq		e Can	liovas	eular),	Visen	٩	Onset and Death
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rds, P.	quires that n signed l	by	Part II. Other significant of	conditions of	ontributing to de	eath but not res	ulting in the u	nderlying cause (	given in Part I.	23e. Did t	V	ntribute to th	he cause of death?
Records,	The law requir sete has been si page 2 should	Completed								24a. Was autop perfo		prior to cor death?	psy findings available mpletion of cause of
_		e Co	25. Was case referred to	medical				<u>-</u>	26, Place of Dea		_/	1 🗆 Yes	21170
>	Phyelclan: r this certific ral director,	To B	examiner?	ouisu.	Hospital: 1VI	npatient 2	ER/Outpatier	t 3 DOA	ther	ome 5 Resid		her (Specif	v)
	g Phy er thi		27. Manner of Death		28a.	of Injury th, Day Year)	28b. Time of	28c. In			how injury occu		
jo	ath. r: After ne funer	atio	1 Natural 5  2 Accident	Pending investigation		in, Day Tour)	injury		☐Yes 2☐No				
Division	or Atter de after de Directo	Certification;	3 Suicide 6 4 Homicide	Could not be determined	28e. Place	of Injury - At ho ng, etc. (Specif		eet, factory, offic	е	28f. Location (S City or Tox	Street and Num wn, State)	ber or Rura	al Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai C			iner: On the ba				time, date and place opinion, death occu				
	To th within To th compl	Me	29b. Signature and title of	certifier	20	-1		29c. Lice	nse number		29d. Date signe	ad (Month,	Dey, Year)
)	/		1 sty	1//	1 aug	mer	'n	D	-/397/		4/1	7/0	5
	5		30. Name and address of	person who	completed caus	e of death (Item	n 23a) (Type,	Print)			1	1-	
	~		Robert L		mann / 3			St./ Fi	rederick,	Marylan	d 21701		
	Sta Registi		31. Date filed (Month Day	R 1 9 2	2005 32.	gistrar's Signa	ture	South!					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item/29a per DVR G843.5/2/05 TT State of Maryland? Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Martha Marie Harris 2005 9:18 P M 15, April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Beverly Healthcare Center Frederick Frederick If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 ☐ M 2 📆 F 91 Yrs. 220-32-6709 Director Sept.9, 1913 North Carolina Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryla Department of Heelth and Mental Hyglene. Importent: If item 27 is marked other than "naturel", or items 23s or 28e-1 show any injury or other treumatic event. If a Medical Examiliar in strait be notified at once. 1 ☐ Yes 2X No Director Frederick Monrovia Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? United States 21770 4109 Cove Court by Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No ff Yes, Give 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) School Board Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John L. Cook Margaret Sloop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4109 Cove Court, Monrovia, MD 21770 Donna Wisniewski / Daughter 20b. Pface of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 ☑ Cremation 3 □ Removaf from State 4/19/2005 Frederick, Maryland Frederick Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Home outney 1621 Opossumtown Pike, Frederick, MD 21702 Part). Enter the glease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CETTE BRAL HE MORRHAGE NTRA **Physician** disease or condition resulting in death) /Medical Examiner AILURE 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OSTEO MLTHROSIS 2 No 3 Probably 4 Unknown 1 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 No 1 Yes Physician: funeral director Be 25. Was case referred to medical 26. Pface of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 3□ DOA 2 ER/Outpatient Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Infury 1 Natural 5 Pending 2 No after death. 1 Yes investigation 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitei within 24 hours To the Funerel 29a. Certifier 🔣 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the ! 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 00 47 951 4-18-2005. ·HO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOLL HOUSE AUE . FREDERICIC, 9 क्षाप MD OBTE A. KAZMI strar's Signature 31. Date filed (Month State

DHMH 17 Rev 1/2001

Registrar

		•	1 - State of Maryland / Department	rtment of Health and Me tificate of Death	ental Hygiene
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last)  Robert W. Heath, Jr.		2. Date of Death Month Day Year 77/15 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)  105 Hunters St.	4b. City, Town, or Location of Death  Elkton	4c. County of Death  Cecil
	Funeral Director		5. Social Security Number  218-70-3739  6. Sex 1	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	B. Date of Birth (Month, Day, Year)  Ctober 6, 1958  9. Birthplace (State or Foreign Country)  MD
	Maryland f ehow	or	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Loc	ation	10d. Inside City Limits 1 ☐Yes 2 ☐ No
	or 28e-	Direct	MD Cecil Elkton  10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
036	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural, or Items 23a or 28e-f ehow any injury or other treumatic event, the Medical Examinating trinial termination on other treumatic event, the Medical Examination trinial termination on other treumatic event, the Medical Examination of the restriction of the	by Funeral Director	Amed Forces? If  1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1  3 Widowed 4 Divorced Year or Dates:	21921 Vas Decedent of Hispanic Origin? (Specifyes, specify Cuban, Mexican, Puerto Ri  ☐ Yes ※ No Specify:	U.S.A.  Ify Yes or Nocan, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036	within 72 ho ane. than "natur is Medical.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) Rea	ent's Usual Occupation kind of work done during most of working DO NOT use retired)	Real Estate
<u>2</u> ک	e filed value of Hygie other t	Be Co	17. Father's Name (First, Middle, Last)	altor 18. Mother's Name (	First, Middle, Maiden Surname)
rylar	a Menta narked natic ev	ToE	Robert W. Heath, Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailin		M. Horn
Ma,	and 2 sl aith an 27 is r er treur			Hunters St., Ell	Route Number, City or Town, State, Zip Code)  Kton, MD 21921
altimore,	iges 1 and of the street or other		20a. Method of Disposition  ★ Burial 2 Cremation 3 Removal from State  20b. Place of Disposementary, crem	sition (Name of Da natory or other place)	te 20c. Location - City or Town, State
altin	mit. Pa partmer sortent / injury		. 4 □Donation 5 □Other (Specify)  21. Sign 14 □ Sept) Ce Licensee  Cherry I  Methodis	st-cemeters	O5 EIRCON
ã	permi Depa impo any in		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter	Andrew G. Gee Fi 2 <del>59 E. Main St.</del>	
Market K	Pnysician /Medical Examiner	e.	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	ateral Sclerosis	Interval Between
8760,	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):		
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	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1
Vital Records,		Completed	<u>'</u>		24a. Was an autopsy performed?  1 \[ \sum 8 = 2 \sum \text{No} \]  1 \[ \sum 9 = 2 \sum \text{No} \]  1 \[ \sum 9 = 2 \sum \text{No} \]  24b. Were autopsy findings available prior to completion of cause of death?
	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (	
n of	ng Phy fter this	on: To			e 5 X Residence 6 Other (Specify)  Id. Describe how injury occurred
Division	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director,	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No eet, factory, office	if. Location (Street and Number or Rural Route Number, City or Town, State)
_	To the Hospitel within 24 hours a To the Funerel i completely filled	edical Co		occurred at the time, date and place, an restigation, in my opinion, death occurred	d due to the cause(s) and manner as stated. If at the time, date and place, and due to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
•	(0		30. Name and addre's of person who completed cause of death (Item 23a) (Type, F	1715314 Print)	April 17,2005
	<u> </u>		14. Farkas, no, Union Hospit	1 / - 1 -	
	Sta Registi		APR 1.9 2005		

DHMH 17 Rev 1/2001

			For State Registrar		laryland / Dep		of Health a of Death		Reg. No. UU5	14844
3	 Physici /Medio		1. Decedent's Name (First, Middle, Las Michelle Ange	,	kson			2. Date of D Month APRIL	Day Year	3. Time of Death  11:00p M
	Examir		4a. Facility Name (If not institution, give				own, or Location o		4c. County of Dea	th
	Funeral		N/B BWI PARKWAY NO 5. Social Security Number 6. S		LUCK ROAD ge (In yrs. last birthda	HYATTS		24 Hrs. 8. Date of B	PRINCE G	
L	Director		579-90-1009	□M 2 🛣 F	43 Yrs.	Months [	Days Hours	Min. July	Day, Year)	thplace (State or Foreign country)
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	the Marylar 28a-f show notilited at	ctor	Md. P.G.		Hyatts	ville				1X∑Yes 2 □ No
	with the	Funeral Director	10e. Street and Number			10f. Zip C	ode 0781		10g. Citizen of What C	-
	ms 23	erai	5202 60th Aver	12. Was Deceden	t Ever in U.S. 1:			nin? (Specify Yes or N	United St	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Misdical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 If Yes, Give Year or Dates:	No	If Yes, specify  1 ☐ Yes 2 ☐		gin? (Specify Yes or N , Puerto Rican, etc.)	Specify:	
21215-0036	72 ho "natur	Completed	15. Decedent's Ec	lucation de completed)	16a. Dec	cedent's Usual ( ve kind of work	Occupation done during most retired)	of working	16b. Kind of Business	
2121	iene. than the M	omp	Elementary/Secondary (0-12)	College (1-4or	5+1	. DO NOTUSE Housew:			Private	
	12 should be filed within h and Mental Hygiene. 7 is marked other than "rearmatic event, the Mag	Be C	17. Father's Name (First, Middle, Last)					r's Name (First, Middl	e, Maiden Sumame)	
Maryland	hould to d Ment marka matic	ပ	Wayne Jones  19a. Informant's Name/Relationship (	Circo (Brint)	10h 14e	ilia Addass (C		Hodges		
	1 and 2 s Health an em 27 ls i		Willie L. Jack		band Su	23 Hud itland	son Ave Md. 2	7 O7 HUM HOUTE NUM PO 746	ber, City or Town, State,	Zip Code)
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr. once.		20a. Method of Disposition 1  Burial 2  □ Cremation 3 □	Demoval from State	20b. Place of Dis	position (Name rematory or other	of er place)	Date	20c. Location - City or	Town, State
tim	Pa ant: ury	4	`4 □ Donation 5 □ Other (Specify	1)	Harmony	Mem.	Park 4		Landover	
Ba	permit. Departr Importa any inju		21. Sign-ture of Funeral Service Lices	Turul	.//			_	& Edwards Suitland	
100	/Medical Examiner whysician and the burial-transit	dicai Examiner	sbock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a		INTVR	-165			Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death	3 □Ectopic preg 5 □ Other (spec			23d. Date of de Month	livery Day Year
	quires tha n signed uld be de	þ	Part II. Other significant conditions of	ontributing to death	but not resulting in the	underlying caus	se given in Part I.		tobacco use contribute to	the cause of death?
al Records,	ilclan: The law requ certificate has been rector, page 2 should	Completed						per 12 Yes	opsy prior to death? 2 □ No 1,2 Yes	utopsy findings available completion of cause of
of Vital	S S	To Be	25. Was case referred to medical examiner?  1 ☒ Yes 2 ☐ No	Hospital: 1 ☐ Inpat	ient 2 ☐ ER/Outpat	ient 3□ DOA	0.1	of Death (Check only	one) sidence 6 <b>X</b> Other (Spe	city) SCENE
			27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		ury 28b. Time	of 28c	linjury at Work? 1 ☐ Yes 2 ☑ N	28d. Describe	how injury occurred	
Division	- 0 Ω	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inbuilding, e	njury - At home, farm, tc. <i>(Specify)</i>	street, factory, o	office	City or To	(Street and Number or Richard, State) 95 HYATTSVIL	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 1 ☐ Medical Exam	ysician: To the bes niner: On the basis and manner s	of examination and/or	ath occurred at investigation, in	the time, date and my opinion, death	place, and due to the h occurred at the time	e cause(s) and manner as , date and place, and due	s stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	and mainlef S		29c. L	icense number		29d. Date signed (Mont	h, Day, Year)
			> aueIn_				OCME		APRIL 08, 2	005
M	2(3)		30. Name and address of person who	completed cause of	death (Item 23a) (Typ		Penn Str	eet Baltim	ore, Maryla	nd 21201
:	Sta Registr		31. Date filed (Month, Day, Year)  APR 1 9 2005	- Regist	trar's Signature				, 1111/14	2201

AMANDA E. JONES

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,

		1 - For State Registrar	State o	f Maryland	•	artment rtificate					giene	105	11.	01.5
sicia		Decedent's Name (First, Midde     AMANDA E. JONE	,,							2. Date of Dea	ath	2005	3. Time 8:55	of Death  P M
imin		4a. Facility Name (If not institution Salisbury Nurs			ter	4b. City,	Town, or	Sali	sbur	y, Md.		omico		
eral tor		5. Social Security Number 217-01-8652 Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. In 94	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Dat 09-24-	1910	9. Birth	nplace (State yntry) TON, MA	e or Foreign ARYLAND
T PAIN	ctor	10a. State 10b. Count	omico		V. Town or Lo								10d. Inside	City Limits
MAIL AND LINE	eral Director	10e. Street and Number 36610 MT. PLEA		edent Ever in U.S		10f. Zip	21	874	-:-0.10		10g. Citizen o	US	A	
al Ezalida al Imal de Louinea di	d by Fune	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	Armed Formation Armed Formation I ☐ Yes If Yes, Gi	orces? 2 ☑ No ve X	-	f Yes, spec		Specify:		city Yes or No- Rican, etc.)	Spec	lack, White	rican Indian, a, etc. HITE	
MEDIE	ompietec		nt's Education est grade completed) College (	1-4or 5+)	(Give life.	dent's Usua kind of wor DO NOT us IENT W	k doné d e retired)	uring mos	t of workii	ng	16b. Kind of			
reumatic event, me	To Be Co	17. Father's Name (First, Middle WILLIAM CLAYVI	· ·					18. Moth	er's Name E DEN	(First, Middle,	Maiden Surn	ame)		
		19a. Informant's Name/Relation GERTRUDE WILKI 20a. Method of Disposition				MT.	PLEA		ROAI	Route Number  WILL  ate		MARYL	AND 2	1874
njury or otner		1X Burial 2 □ Cremation 4 □ Donation 5 □ Other (  21 Signature of Funeral Service	Specify)	State C6	PLEASA	NT CE	her place METE	RY 0	4-20-		WILLAR	DS, M	ARYLAI	ND
once		23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications that	cau ed the death	70	5 EAS	T MA	IN S	TREE!	F,SALIS	BURY,M			nate
ian cal ner	i Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter the chirthy Cause (Disease or injury that initiated events resulting in death) Last	a. Due to b. Due to c.	(or as a conseque	gence of):	an	d	er c	8-2			7	Onset an	d Death
delached for use as life to	hysician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live I	tcome of pregnar pirth 2 Fetal nant at time of de own	death 3	Ectopic pre						Date of deliment	very Day	Year
z snould be deta	d by P	Part II. Other significant condit	tions contributing to d	eath but not resu	ilting in the u	nderlying ca	use give	n in Part I			bacco use co			f death?
bade	Complete											prior to c death?	topsy finding ompletion of	s available cause of
in by the funeral director,	ertification: To Be	3 Suicide 6 Could	Hospital: 1  28a. Date (Montigation 1 not be remained 28e. Place		ER/Outpatier 28b. Time of Injury me, farm, str	M 28	Bc. Injury Work 1 🗆 Y	4 2 45 at	rsing Hon 2 No	(Check only one 5 Residence Red. Describe has the Residence Red. Location (Society or Town	ence 6 0  ow injury occi	urred		umber,
completely titled in by	ledical Ce	29a. Certifier (Check only one)  1 Certify 2 Medica	ing Physician: To the Il Examiner: On the b and man	e best of my know asis of examinationer stated.	vledge, death ion and/or in	n occurred a vestigation,	at the time in my op	e, date an inion, dea	d place, a	and due to the o	ause(s) and radate and place	manner as e, and due	stated. to the cause	H(S)
Some Some	M	29b. Signature and title of certification	Then				License	number § j	(2)	0	29d. Date sign	ned (Month	, Day, Year)	
3		30. Name and address of perso WILLIAM ROBINS 31. Date filed (Month, Day, Yea	, M.D. 2	se of death (Item OO CIVI(	C AVE.		SBUR	Y, MI	). 2	1804	' /			
Sta gistr				Grave )		book	,							

ADH INDIA N. JACKSON 05-2661

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

260	61		For State Registrar	State of Maryland / De	epartment of Heal		, ,	iene		
	Physic /Medi		1. Decedent's Name (First, Middle, L	<sup>ast)</sup> ia N. Jackson			2. Date of Deat Month		O5	3. Time of Death
	Examir		4a. Facility Name (If not institution, g PRINCE GEORGES H	OSPITAL	4b. City, Town, or Local CHEVERLY			4c. County PRINC	E GEC	RGES
	Funeral Director		5. Social Security Number 6. 578-02-1030  Usual Residence of Decedent	Sex 7. Age (In yrs. last birtho	Months Days Ho	Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, July 8,	1980	9. Birthp Cour Wa	place (State or Foreign ntry) Sh., DC
	the Maryland 28e-f show	Director	10a. State 10b. County	10c. City, Town o	Capitol Hei	ghts		Og. Citizen of		10d. Inside City Limits 1 XYes 2 □ No
	3a or	i i	7243 G St.			0743	11			tates
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "naturel", or Items 23a or 28e-f show amy injury or other treumatic event, I'm Medical Examinan Lines I are rediffied at ance.	by Funerai	11. Marital Status  1   Xever Married   2   Married   3   Widowed   4   Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of Hispan If Yes, specify Cuban, Me		cify Yes or No- Rican, etc.)	14. Rac	ce - Americ ck, White,	can Indian,
21215-0036	within 72 ho ene. than "natur he Medical.	Completed	15. Decedent's (Specify only highest g	Education 16a. Do (G	ecedent's Usual Occupation live kind of work done during fe. DO NOT use retired)	g most of workin	g	16b. Kind of B		,
	filed v Hygie other t	e Co	12th 17. Father's Name (First, Middle, Las	st)	Office Cl	Mother's Name	(First, Middle, N	Maiden Suman	Priv	ate
yla	nould be d Mental narked c	To B		Jackson, Jr.			Cyntia	Finch		
	and 2 sh salth and n 27 is rr		19a. Informant's Name/Relationship Harry D. Jackso		ailing Address (Street and N 7243 G St., C				State, Zip 20743	
ž	Pages 1 a nent of Hea nut; if item iry or othe		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec	Removal from State cemetery,	isposition (Name of crematory or other place)  Memorial Par			20c. Location - Land	City or To	
Balti	permit. Page Department importent; if any injury or once.		21. Signature of Funeral Service Lice		22. Name and Address of 4001 Eenni	Facility St	ewart F			019
	hysician /Medical Examiner		23a. Part / Inter the disease, or co shock, it heart failure. List onl Immediate C. se (Final disease or condition resulting in death)	nplications that caused the death. Do not yone cause on each line.  a	enter the mode of dying, su	ch as cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
Н	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to winterfacts cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  C.  Due to (or as a consequence of):						
Box 6	death certifi e attending id for use as	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Ves 2 □ No 9 ☑ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			1	te of delive	ery Day Year
rds, P.	es pe		Part II. Other significant conditions	contributing to death but not resulting in th	e undertying cause given in	Part I.	23e. Did tob	h		ne cause of death?
Rec	2 0 0	Completed					24a. Was ar autopsy perform	y _   I		psy findings available mpletion of cause of
	ding Physicien: The lav h. After this certificate has funeral director, page 2	To Be	25 Was case referred to medical examiner?  13 Yes 2 No  27 Manper of Death 1 Natural 5 Pending investigatives	Hospital: 1 ☐ Inpatient 2 🏋 ER/Outpa 28a. Date of Injury (Month, Day Year) 28b. Tim Inju	e of 28c. Injury at	_	(Check only one	nce 6 Oth	er (Specify	
Ö	or Attending Ph after death. I Director: After th I in by the funeral	Certification:	2 Accident Investigate 3 Suicide 6 Could not 4 Homicide determine	be as Place of Injury - At home form			Bf. Location (Str. City or Town,	reet and Numb , State)	er or Rura	l Route Number,
	To the Hospitel within 24 hours a To the Funerel C completely filled i	Medical C	29a. Certifier (Check only one)  1 Certifying F  (Check only one)	rhysicien: To the best of my knowledge, d miner: On the basis of examination and/o and manner stated.	eath occurred at the time, dar r investigation, in my opinion	ate and place, ar	nd due to the ca d at the time, da	use(s) and ma	and due to	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	10	29c. License num OCME			d. Date signer	d (Month,	Day, Year)
7	(3)		30. Name and address of person	o co eted use of death (Item 23a) (Ty	na Print\				16. 2	_
			NoThy C.	RIPLES	111 Peni	n Street	t Balti	imore,	Mary]	land 21201
	Sta Regist		31. Date file (Month, Day, Y + r)  APR 1 9 200	32. Registrar's Signature	ile					

DHMH 17 Rev 1/2001

4b. City, Town, or Location of Death

CLINTON

For State Registrar

1. Decedent's Name (First, Middle, Last)

KATIE

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL

State of Maryland / Department of Health and Mental Hygienery Certificate of Death

JOHNSON

Reg. No.

APRIL 14, 2005

Year

4c. County of Death PRINCE GEORGE

2. Date of Death

17:24 P M

		Physic /Med Exami	ical
ľ		unera irecto	
	ne Maryland	Sa-f show	ector

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12–11–46 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 X F 58 Yrs 240-72-4393 NORTH CAROLINA Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 Yes 2 No MARYLAND PRINCE GEORGE TEMPLE HILLS 10e. Street and Number filed within 72 hours after death with th Hygiene. 10f. Zip Code 10g. Citizen of What Country? or 2 other traumatic event, the Medical Exactions must be no Dir. 20748 3308 DALLAS DRIVE U. S. A. or items 23a Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2☐**X**No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced BLACK Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 2 YRS. + LENDER PROCESSOR NAVY FED. CREDIT UNION and Mental Hygie is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CLARENCE JOHNSON VIOLA FRAMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY O. J. STATON-SISTER 3409 SWANN ROAD SUITLAND, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State EAST LAWN CEMETERY 4-23-05 TARBORO, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility PINCKNEY-SPANGLER FUNERAL HOME 21. Signature of Funeral Service Licensee heodore 524 - 8TH ST., N. E. WASHINGTON, DC 20002 Approximate Interval Between Onset and Death art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** RNO 0 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trans and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2. No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 this certificate has 1 Yes or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner<sup>a</sup> Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1- Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 2 No investigation 1 Tyes 2 Accident after death Director: the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20039691 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Temph Hills 44 4 0

State

Registrar

31. Date filed (Month)

Year 1 9 2005

			For State Registrar	State of Maryland	-	artment <i>tificate</i>			ind Me		giene Reg. No. 🥎	Ope	
	Physicia		Decedent's Name (First, Middle, Last)     CHARLES OLIVER	JOHNSON, SR.		70			1	2. Date of Dea Month April	Day 12	2005	3. Time of Death 6:00 A M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, To	own, or l elph				4c. Co	unty of Death	
ì	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) Yrs.	If Under 1		If Under 2 Hours	Min.	B. Date of Birt (Month, Day May 23	h	9. Birth	nplace (State or Foreign
	Director		248.20.9435  Usual Residence of Decedent  10a. State 10b. County	10c. City, T		cation				May 23	, 192	J Sout	th Carolina  10d. Inside City Limits
	e Maryli Ba-f sho	ctor	Maryland Prince G	eorge's Ade	1phi								1 ☑ Yes 2 ☐ No
1	3a or 2	al Dire	10e. Street and Number 9719 Riggs Road			10f. Zip C		783			10g. Citizer U • S	of What Co	untry?
မ္	n 72 hours after death with the Marylan "naturel", or Items 23s or 28s-f show edical Executive finast be rotified at	by Funeral Directo	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give WW II Year or Dates:		Was Decede f Yes, specif			gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		Race - Amer Black, White ecify: Wh	e, etc.
Maryland 21215-0036		Completed I	15. Decedent's Edu (Specify only highest gradi	cation 1 e completed)  College (1-4or 5+)	(Give life.	dent's Usual kind of work DO NOT use	done du retired)	ıring most	of working	g		of Business/I	·
ב סנ	e filed with il Hygiene. other ther vent, tre N	Be Cor	17. Father's Name (First, Middle, Last)	4 Years	Log	istici		18. Mothe	r's Name	(First, Middle,		Gover:	nment
rylar	should be and Mental s marked o umatic eve	ToE	Leslie Johnson  19a. Informant's Name/Relationship (Ty	ne Print)	l9b Mailir	na Address (	Street at		r or Bural	ae Wil	11iams		in Code)
	es 1 and 2 should of Health and Me I item 27 Is mark r other treumation		Charles O. Johnso	n, Jr/Son	719	Riggs	Roa		le1ph	i, Mar	yland	20783	
nore	Pages 1 ment of He ant: If iter ury or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	ceme	etery, crer	sition (Name natory or oth .oln Ce	ier place			/2005		ion - City or $vood$ .	Town, State Maryland
	permit. Pages Department of I Important: If its any injury or of		21. Signature of Funeral Service Licens	(acenty	1	1800 N	lew_l	lamps	hire		ilver	Sprin	ng, MD 20904
, ,	Trysician		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	Dementia		er the mode	of dying	, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death Years
	/Medical Examiner			Due to (or as a consequent Atherosclerot	ic Ca	ardiov	ascı	ılar	Disea	ase			Years
	uted d ansit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequen	ce of):								
8760,	death certificate be executed eattending physician and of for use as the burial-transit	dicai Exa	resulting in death) Last	Due to (or as a consequend.	ce of):								
Box 68	eath certifica attending ph for use as tt	n/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy		Dec.					230	. Date of deli	very
P.O. B	that the death ted by the atte detached for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pred Other (spec						Month	Day Year
Ś	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions conditions and Abdominal Aneury	•	ng in the u	nderlying cau	use give	n in Part I.	_		obacco use Yes 2X		the cause of death?
Œ	The ate h page	Completed								24a. Was autop perfo 1 Yes	rmed?	prior to death?	topsy findings available completion of cause of
Vital	ysicien: Th is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatier	nt 3 DOA	Othe			(Check only o		Other (Spec	cify)
Division of	ding Ph .r After th funeral	ation: T	27. Manner of Death  1 ☑ Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year) 28	b. Time of Injury	f 28	c. Injury Work 1 🗆 Y	at	2	8d. Describe h			
	al or Attendes safter desti	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory,	office		2	Bf. Location (5 City or Tow		lumber or Ru	ral Route Number,
	To the Hospital or Al within 24 hours after of To the Funerel Direc completely filled in by	edical (	29a. Certifier 1 ★ Certifying Phy (Check only one) 2 ★ Medicel Exemi	sicien: To the best of my knowle ner: On the basis of examination and manner stated.	dge, deat	n occurred at vestigation, i	t the time	e, date and inion, deat	d place, ar th occurre	nd due to the d at the time,	cause(s) an date and pla	d manner as ace, and due	stated. to the cause(s)
)	To the Ho Within 24 I To the Fu completely	Ň	29b. Signature and title of certifier	a Dolan	6	29c,	License	number 7	12	3	29d. Date s	igned (Month	1, Day, Year) 14/2005
	10		30. Name and address of person who come Mary Dobyns, M.D.				Suit	e #32	0. L	aurel.	Marv1	and 20	707
4	Sta Registr		31. Date filed (Month, Day, Year) APR 18 20	32. Pegistrar's Signature	_								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 2005 **Physician** APRIL 16 6:10 PM M Yvonne L. Kahlert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🕅 F Yrs Director 476-26-6092 74 Minnesota Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 ☐ Yes 2 No Directo Maryland Frederick New Market 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11297 Country Club Road 21774 United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 □ Yes 2X□ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) <u>Homemaker</u> Own Home permit. Pages 1 and 2 should be fit. Department of Health and Mental Hy, Important: If item 27 is marked any injury or other? 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be David B. Benedict Myrtle J. Olsen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11297 Country Clum Road, New Market, MD 21774 William Kahlert / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Frederick Crematory 4/20/2005 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 au 236. Part 1. Enter the disease, or complications that laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) obstructive pulmonary disease **Physician** Chronic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner anding physician and use as the burial-transit so the Hospitel or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0051347 4/18/05 Untura

State Registrar 6701

N. Charles St. Bultimore MA 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sociano

31. Date filed (Month, APR earl 9

		1	State of Maryland / Department of Health and Me 1 - State Registrer Certificate of Death	ental Hygier	Z11115	14850
	Physicia		1. Decembra Name (1 Mat, Mindue, East)	2. Date of Death Month APRIL 12	2005	3. Time of Death
	/Medic	al L			4c. County of Death	9:00 A M
	Examin	er <sup>4</sup>	4a. Facility Name (If not institution, give street and number)  Shady Grove Adventist Hospital Rockville		MONTGO	1
_	Funeral		5 Social Security Number 6 Sey 7 Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		186-18-2777 1 M 2 M F 82 Yrs. Months Days Hours Min.	$Mar.5^{Month,Day,Yas}$	23 Ge	Örgia
	D ≥	H-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Aaryla I sho		MD Montgomery Montgomery Village	e		Yes 2□No
	28a-	Director	10e. Street and Number 10f. Zip Code		Citizen of What Cou	ntry?
	h with		18722 Walkers Choice Road 20886		U.S.A.	
	ems 2	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	within 72 hours after death with the Maryland ene. Then "natural", or Items 23e or 28a-f show he Medical Examiner must be notified at	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 2 □ No Specify:  3 ☑ Widowed 4 □ Divorced Year or Dates:		Specify: Bl	ack
21215-0036	tural	ed t	15. Decedent's Education 16a. Decedent's Usual Occupation	16b.	Kind of Business/li	ndustry
215	hin 72 3. 30 "na	plet	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  (Give kind of work done during most of working life. DO NOT use retired)			
2	ad wit	Completed	8th Governess		Private	Со
und	be file	Be	17. I altrici o razino (r. nas) massej ezesy	(First, Middle, Maid ie Alma		n
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Importent: If item 27 is marked other than "natural; or Items 23e or 28a-f show enyportent: If item 27 is marked other than "natural; or Items 23e or 28a-f show injury or other traumatic event, tra Medical Examinating rust be notified at once.	L C	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural			
Ma	ith an 27 is i		Charles Johnson (Son) 18722 Walkers Choice	ce Rd.,	Montg.	Vlg,MD
re,	of Heal		complete, cramatory or other place)	ate 20c.	Location - City or T	own, State
Ë	Page ment of m			/05 Ph		
Baltimore,	permit. Departrimporte Importe eny inj		21. Signiture of Facility Sno			
ш	⊈0 2 9 d		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or		IIe, MD	ZU85U Approximate
	e enve		shock or heart failure. List only one cause on each line.			Interval Between Onset and Death
	Pny <del>sicia</del> n /Medical		Immediate Cause (Final disease or condition resulting in death)  a.   VENTRICULAR F; BRILLAT, Due to (or as a consequence of):	ON		LIMEDIAIL
П	Examiner					
	7 =	ner	Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury			
	and transi	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):			
8760,	ate be executed hysician and the burial-transit	Ical E	bus to (or as a consequence or).			
687	tificate g phys as the		d.			
Вох	death certifica e attending ph id for use as th	Physiclan/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deli	
	ne death the atte	sicla	in the past 12 months?  1 ☐ Yes 2 ☐ No  4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year
P.0	<b>⇒</b> > 3	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Š,	es g	by	Par II. Other significant continuous continuous to death out not resulting in the discerning cause given in Fact.	1 ☐ Yes		
Records,	w requir been si should	ompleted		24a. Was an	24b. Were au	opsy findings available
Rec	The law ate has page 2	ldm		autopsy performed	? ] death?	opsy findings available ompletion of cause of
Vital		CO	25. Was case referred to medical 26. Place of Death	1 ☐ Yes 2 ☐	PRO ILLITES	2 140
Ξ	S S	o B	examiner?   Hospital	me 5 🗆 Residence	6 □Other (Spec	ify)
n of	ter in	J: UC	1 Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how in	njury occurred	
Sio	Attending r death. ector: Atter	catle	2 Accident investigation M 1 Yes 2 No	28f. Location (Street	t and Number of Pu	ral Pouto Number
Division	of or Attendir after death. Director: At I in by the fu	Certification:	3 Suicide 4 Homicide  5 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, Si		rai noute Number,
_	To the Hospitel or within 24 hours after To the Funeral Director completely filled in b		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the cause	e(s) and manner as	stated.
	the Hos nin 24 h the Fur npletely	edical	(Check only one)  2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, date	and place, and due	to the cause(s)
	To th Withir To th	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month	Day, Year)
)	2		M.D Deo 3 4139	HI	RILIZ	2003
	V		29a. Certifier (Check only 2   Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a considerable of the construction on the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  29b. Signature and time of certifier  29c. License number	HERS BUR	ec, Mo	
	St Regist	ate rar	31. Date filed (Month, Day, Year)  APR 18 2005  Registrar's Signature			
			I THE STATE OF THE			

amend item#20c, perFH, 6843,5/12/05 TI
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** APRIL 13 2005 5:30 A TRIXIE MCCT.ATN /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's 16010 Excalibur Rd # B-314 Bowie If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 916 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 M 2 F 88 Yrs November 24 North Carolina 242-32-2629 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Yes 2 No Director MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16010 Excalibur Road B-314 20716 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2€ No Specify. Specify: **Black** þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Home Maker Aid 9th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lelar Shipman ပ Richard George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda E. Williams/Daughter 2307 Bermondsey Dr. Mitchellville, Maryland 20721 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition emetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Résurrection Cemetery 4/19/05 4 □ Donation 5 □ Other (Specify) Clinton, MD Jenkins Funeral Home 21. Signature of Funeral Service Lightsee 22. Name and Address of Facility J. B. 20785 7474 Landover Road Landover, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DEPSI S 6 months Due to (or as a consequence of) Peripheral 2 year Vasau Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Examiner Stas End Due to (or as a consequence o) OFONAF Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Monknown ension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2X No 2

▼ No 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 🕱 Residence 6 Other (Specify) 1 Tyes 2 No

Physician /Medical **Examiner** 

**Funeral** 

Director

Show

28a-f

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or Itams 23a

natural

l Hygiene.

perriit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If tem 27 is marked other any, njury or other traumatic svent, once.

72 hours after

Baltimore, Maryland 21215-0036

traumatic svent, the Mudical Examiner must be notified at

Physician: The law requires that the death certificate be executed burial-transit attending physicien has this After

P.O. Box 68760, of Vital Records, or Attanding after death. filled in by 24 hours a

within 2 To the

2 Certification:

Medical

27. Manner of Death 5 Pending investigation 6 ☐ Could not be determined 4 🗌 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

H0052843

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) 4-14-2005

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (It = 23a) (Type, Print)

4000 Mitchellville Rd. # 422 Bowie, Maryland 20716 Peter Swaby M.D.

31. Date filed (Month, Day, Year) State APR 1 9 2005 Registrar

1 Natural

29a. Certifier

2 Accident 3 Suicide

(Check only one)

29b. Signature and title of certified

Registrar's Signature

			1- For Amend Item 1 Registrar	Oe per b	VR, C845, 07	12705dhb ertificate of L	lealth and I Death	Mental Hygier		11.850
	Physic	ian	1. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month	Day Year	3. Time of Death
	/Medi		Estelle 0.	Moore				April 1		11:30 A M
	Exami	ner	4a. Facility Name (If not institution, give	street and numbe	or)	4b. City, Town, or	Location of Death	1	4c. County of Death	
			Hilltop House  5. Social Security Number 6. S	av 7 /	Ago (lo ure lock himb de		sville		Howar	
	Funeral Director			9X	Age (In yrs. last birthda 84 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea Sept. 5,	1920 Mary	place (State or Foreign intry) land
	72 hours after death with the Maryland neturel; or Iteme 23a or 28a-f show licel Examiner must be rediffed at		10a. State 10b. County		10c. City, Town or	ocation				10d. Inside City Limits
	Mar Mar	ţċ	Maryland Howard		Clark	sville				1 □Yes 2 No
	or 28	Director	10e. Street and Number 6538			10f. Zip Code		10g. (	Citizen of What Cou	intry?
	ath wi	a	6540 Haviland Mi	11 Road		2102	:9	U	nited Sta	ites
	er dez	Funeral	11. Marital Status	<ol> <li>Was Deceder Armed Forces</li> </ol>	s?	. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 ☐ If Yes, Give		1 ☐ Yes 2 🕱 No	Specify:	, ,		ite
Ş	turel ture		15. Decedent's Ed	Year or Dates		adapt's Usual Casus	Minn	140		
5	n ne	Completed	(Specify only highest gra	de completed)	(Giv	edent's Usuaf Occupa e kind of work done o DO NOT use retired	turing most of wor	king 16b.	Kind of Business/Ir	ndustry
Maryland 21215-0036	d within giene. r then "	E	Elementary/Secondary (0-12)	College (1-4o		eller			Banking	
פַ	be filed within 72 hours after death with the Marylan ital Hygiene. Id other then "neturel", or Iteme 23a or 28a-f show event, it a Medical Exprintment percentilised at	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, Maide		
<u> a</u>	should be find Mental finarked of	To E	John Henry Oldfi	eld			Helen	E. Phillip	s	
ar	~ 4 4 4		19a. Informant's Name/Relationship (7	ype, Print)	19b. Ma	ling Address (Street a		ral Route Number, City		p Code)
	of Health item 27 I		Linda hughes /	Daughter	7603	Woodville	Road M	t. Airy, M	aryland,	21771
			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from Stat	20b. Place of Disp cemetery, cr	position (Name of ematory or other place	9)		Location - City or T	own, State
Ē	permit. Pages Department of I Importent: If its any Ihjury or o once.		' 4 ☐ Donation 5 ☐ Other (Specify		Frederic	k Cremator	y Apri	1 22, 2005' Fre	derick, N	Maryland
Sail	permit Depart Import any ih pnce.		21. Sign ture of Funeral Service Liceo	S00		22. Name and Addres	s of Facility St	auffer Fun	eral Home	s, P.A.
_								d. Mt. Air	y, Maryla	nd 21771
	nysician /Medical		23a. Part1. Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each	us a consequence of):				(Days,	Approximate Interval Between Onset and Death
	cate be executed  physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	is a consequence of):	es Ourser				Y/APCS
POX O	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliver	ery Day Year
J	requires that the leen signed by th hould be detache	by Pi	Part II. Other significant conditions co	ntributing to death	but not resulting in the	underlying cause give	n in Part I.	23e. Did tobacco	use contribute to the	he cause of death?
	quire in sig uld bi		Dank	WMA A	Weinge	<u></u>		1 ☐ Yes	2 □ No 3 □ Prob	pably 4 Unknown
ပ္သ	sw requir s been si s should	Completed	SE 71	not nu	ornán			24a. Was an	24b. Were auto	psv findings available
ב	Inelawi ate has be page 2 sh	шo	(1)		20-6 0	11/21/2		autopsy performed?	m death?	psy findings available impletion of cause of
<u> </u>		0	25. Was case referred to medical	4474	muny 1	31405	26. Place of Deat	1 ☐ Yes 2 ☑N h (Check only one)	o 1 ☐ Yes	2LJ NO
or Vital Record	di S	To B	examiner?	Hospital: 1 🗌 Inpat	tient 2 ER/Outpatie	Otho	e.	ome 5 Residence	6 ☐Other (Specif	v)
	ding Fn h. After thi funeral		27. Manner of Death	28a. Date of Inj (Month, D		of 28c. Injury Work		28d. Describe how inju		,
2	Attending ir death. ector: Alter by the fune	atlo	1 Matural 5 Pending 2 Accident investigation		ay roary migary		es 2 No			
5	el or Atten s after deat al Director: ad in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	286. Place of It	njury - At home, farm, s etc. <i>(Specify)</i>	treet, factory, office		28f. Location (Street a City or Town, State		l Route Number,
:	to the hospital of Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical (	29a. Certifier (Check only one)	rsician: To the besiner: On the basis and manner s	t of my knowledge, dea of examination and/or instated.	th occurred at the time nvestigation, in my opi	e, date and place, inion, death occur	and due to the cause(s red at the time, date ar	s) and manner as sind place, and due to	tated. the cause(s)
1	vithin 2 To the complet	M	29b. Signature and title of certifier	. 1		29c. License	number		ate signed (Month,	Day, Year)
			Cal 1	1 all	~	72	5947	MIS	16 19, 2	cor
	9		30. Name and address of person who		4-5 4- ( 6	, Print)	01 -		, \	
			Dr. Evelyn Jac	Kson		en Oaks	Rd, C	larksville	· ml) .	21029
	Sta Registr	-	31. Date filed (Month Par Pear) 9	2005 32. Resist	trar's Signature	doneth)				,

			1 - For State Registrar	State of Maryl		artment of H			iene		11.050
	Physic /Med Exami	cal	1. Decedent's Name (First, Middle, Lasi  A D I NE  4a. Facility Name (If not institution, give	street and number)	Mag	4b. City, Town, or	Location of Death	2. Date of Deat Month		Year 2005	3. Time of Death U 2:45 PM
	Funeral Director		Washington Count 5. Social Security Number 217-28-7223 Usual Residence of Decedent		yrs. last birthday) Yrs.	Hagers If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Wash Year) 1932	ningtor 9. Birthplac Country Maryl	n County ce (State or Foreign c)
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show older Examiner must be notified at	sted by Funeral Director	10a. State 10b. County  Maryland Washingt 10e. Street and Number  22148 Holiday I  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edic (Specify only highest grad	PIVE  12. Was Decedent Ever in Armed Forces?  1	16a. Deced	sburg 10f. Zip Code	Specify:	ecify Yes or No- Rican, etc.)	Blac	Vhat Country  State  - American k, White, etc	Inside City Limits  1 □ Yes 2√2 No  ?  ES Indian,
Maryland 2121	d 2 should be filed within th and Mental Hygiene. ? Is markad other than " traumatic event, Ine Ma	To Be Completed	Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last) Carroll W. Morga 19a. Informant's Name/Relationship (T)	College (1-4or 5+)	life. L	Sales Cle	rk 18. Mother's Name Edna Sp	) (First, Middle, M	Morgan	θ)	
ore,	es 1 and of Health fitem 27 r other tr		Charles Morgan M  20a. Method of Disposition  1 X Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	agaha (husba	and) 22° b. Place of Dispos cemetery, cren	g Address (Street a.  148 Holida  Sition (Name of natory or other place  CO Cemeter	ay Dr. Sm	ithsburg		and 21 City or Town,	783 , State
	permit. Pag Deportment Important: I any injury o		21. Signature of Funeral Service Licens 23a. ant 1. Enter the displaye, or or many shock, or heart estire. List only or Immediate Cause (Final	cations that of used the d	13	Name and Address 331 Faster or the mode of dying	Dou rn Blyd	glas A. N Hager	Fiery 1	Funera Maryla: Ap	1 Home
8760,	/Medical Examiner whysician and the burial-transit	ilcai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a constitution of the to (or as a constitution).	sequence of):	defici	rle en	Yeroco i	litis	3	days
. Box 6	that the death certific ed by the attending p detached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th Day	y Year
ທົ	requires een sign hould be		Part II. Other significant conditions cor	stributing to death but not	resulting in the un	derlying cause giver	n in Part I.		acco use contri		ause of death?  4 □Unknown
	The larate has	e Completed	25. Was case referred to medical				26. Place of Death	24a. Was an autopsy perform 1 Yes 2	ed? de	fere autopsy for to comple eath?	findings available ation of cause of
o l	Attending Physician: r death. ector: After this certific by the funeral director,	Certification: To B	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 142 Inpatient 2 28a. Date of Injury (Month, Day Year	ER/Outpatient 28b. Time of Injury	3 DOA Other  28c. Injury a Work?	4 Nursing Hon		ice 6 Othe		
Divi	in Qifte		3 Suicide 4 Homicide  29a. Certifier (Check only) 2 Medical Examin	28e. Place of Injury - A building, etc. (Spe	ecify)	occurred at the time	date and place a	8f. Location (Stre City or Town, and due to the cau	State)	nor an atata d	
:	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of pertifier  30. Name and address of person who o	and manner stated.	ination and/or inve	29c. License o	nion, death occurre number	d at the time, dat	d. Date signed	nd due to the	cause(s)
SH-	Sta Registr	ite	M. E. KROSS, M.  31. Date filed (Month, Par Year)	1136 Opal (	Ct., Hage	erstown, 1	MD 2174	2			

			1 - For State Registrar	State of Marylan		artment of I			iene ig. No. 2005	14854	
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deat	h Day Year	3. Time of Death	
	/Medi		Gladys	McCaulley	У			April	17 2005	6:28 A M	
	Examir	ier	4a. Facility Name (If not institution,				or Location of Dea		4c. County of Deat		
			508 Millwoof Dr 5. Social Security Number 6	ive S. Sex 7. Age (In yrs	last hirthday	Capit If Under 1 Year	tol Heigh		Prince Ge		
	Funeral Director		577-60-5074	1□M 2\\ F 86	Yrs.	Months Days	Hours Min		Year) 9. Birti	nplace (State or Foreign untry) yland	
	P		Usual Residence of Decedent					Traiter 5	IJIJ Hai	yianu	
	arylar show	_	10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits	
	8a-f	ecto		George's C	apito1	Heights				1X Yes 2 □ No	
	with t	D	10e. Street and Number 508 Millwoof Dr	irro		10f. Zip Code 2074	0	10	og. Citizen of What Co	untry?	
	72 hours after death with the Maryland naturel', or Items 23a or 28a-1 show dical Evand without be published at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.	S 13			Specify Ves or No-	U.S.A.	ican Indian	
(0	r Iten	Fun	1 ☐ Never Married 2 ☐ Marrie	Armed Forces?	0. 10.	If Yes, specify Cub	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Black, White		
030	rel', o	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 <b>⊠</b> No	Specify:		Specify: B]	ack	
21215-0036	72 hc	Completed	15. Decedent's (Specify only highest		16a. Dece	dent's Usual Occup	pation during most of wa	nrkina	6b. Kind of Business/l	ndustry	
121	vithin ne. <b>hen</b>	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire					
2	Hygie Thert		12th 17. Father's Name (First, Middle, La	est)	Com	puter Ope		me (First, Middle, M	Governmen	ıt	
and	d be antal l	o Be	David Dorsey	io.			Susie		alden Sumame)		
Maryland	shoul nd Me mark imati	To	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailie	na Address (Street			City or Town, State, Z	in Code)	
	nd 2 alth a 27 Is		Sharron Hill-W							land 20743	
Baltimore,	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel', or Items 23a or 28a-f show appringury or other traumatic event, the Medical Evant activities by multiled at ances.		20a. Method of Disposition		lace of Dispo	sition (Name of natory or other pla	ce)	Date 2	Oc. Location - City or 1	own, State	
Ĕ	Page nent ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3  `4 ☐ Donation 5 ☐ Other (Spe	Theilioval Holli State		11 Cemete		1/2005	Suitland,	laryland	
alt	permit. Departr Importa		21. Signatu e of Foneral Scrvice Li	ASSE					lns Funeral	Home	
Ш	ಕರ= ೨ ಇ		A Del						r,Maryland	20785	
j)	Pnysician /Medical		23a. Part1. Enfer the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	aCardiom	yopath		ng, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death	
	Examiner			Due to (or as a consequ							
	1/43	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Heart Failure  Due to (or as a consequence of):							
	cuted nd ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events  c. Hypertension								
Ő,	ate be executed hysician and the burial-transit	I Ex	resulting in death) Last Due to (or as a consequence of):								
8760,		d									
9	death certifica e attending pl id for use as t	/Me	IF FEMALE:	23c. If yes, outcome of pregnat	004						
Вох	atten atten I for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	delivery Day Year		
o	0 0 0	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
s, D	The law requires that the site has been signed by the bage 2 should be detached.	by P	Part II. Other significant conditions	contributing to death but not resu	Ilting in the u	nderlying cause giv	ren in Part I.	23e. Did toba	acco use contribute to	he cause of death?	
ğ	w require been sig should b	edi						1 ☐ Yes	a 2 □ No 3 □ Pro	bably 4 🛭 Unknown	
Record	law re as be 2 sho	Completed						24a. Was an autopsy	24b. Were aut	opsy findings available impletion of cause of	
		Com						perform	ed? death?	2√ No	
/ita	cien: ertific actor,	Be (	25. Was case referred to medical examiner?				26. Place of Dea	ath Check onl one		21	
of	Attending Physicien: The la rr death. ector: After this certificate has by the funeral director, page 2	2	1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient 2 I			4   Nulsing I		ce 6 □Other (Speci	(y)	
Division of Vital		lon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury		Work?		28d. Describe hov			
ISI	l or Attending after death. Director: After in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined determined					28f Location (Stre	et and Number or Run	el Boute Number	
2	after after Dire	erti	4 Homicide determine	building, etc. (Specify	)	oot, ractory, office		City or Town,		ar mode i varriber,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)  1  Certifying   2  Medical Ex	g Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ca Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, deand manner stated.					ise(s) and manner as s e and place, and due t	stated. to the cause(s)	
	To the within 2 To the comple	M	29b. Signature and title of certifier	. 1		29c. License number 29d. Date signed (Month, Day, Yea					
			Kupa 1	A Vaina	no	<b>D</b> 4	32/1		4/19/0		
R	- (3)		30. Name and address of person wh			Print)		1 2077/			
			Rupa Varma M.D.  31. Date filed (Month, Day, Year)	. 1221 Mercanti  . Registrar's Signat		e Largo,	marylan	20//4			
	Sta Registr		APR 1 9 200		ure						

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician MARY MYERS A	Reg. No. 2 3. Time'd		
Physician MARY MYERS A	Date of Death 3. Time of	055	
/Medical /V/ARY	Month Day Year		
Examiner: 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	1 PRIL 11 2005 4:4:	5 P."	
Examiner 44. Facility Name (if not institution, give street and number)  45. City, Town, or Location of Death  CHEVERLY	P.G.		
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8.  Months Days Hours Min.	Date of Birth (Month, Day, Year) 9. Birthplace (State Country)	or Foreign	
	EPT. 4, 1928 5.	<u>C.</u>	
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside C	City Limits	
MD P.G. CAPITOL HEIGTS	1 Yes	2 □ No	
The state of the s	10g. Citizen of What Country?		
# 5805 SHERIFF RD 20143	USA		
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  11. New Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 11. New Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 11. Ves 2 2 No	y Yes or No- an, etc.) 14. Race - American Indian, Black, White, etc.		
To state 10b. County 10c. City, Town or Location    Capitol   Capi	Specify: BLAC	-14	
1   Yes   2   No   Specify:   1	16b. Kind of Business/Industry		
Elementary/Secondary (0-12) College (1-4or 5+) PHARMACIST	CVS		
The secondary (0-12)   College (1-4or 5+)   PHARMACIST    12   17. Father's Name (First, Middle, Last)   18. Mother's Name (Fi	irst, Middle, Maiden Surname)		
10a. State 10b. County 10c. City, Town or Location CAPITOL HEIGTS  10a. State 10b. County 10c. City, Town or Location CAPITOL HEIGTS  10c. Capitol Heights  10c. City, Town or Location CAPITOL HEIGTS  10c. Capitol Heights	E TRUESDALE	-	
The property of the property o	oute Number, City or Town, State, Zip Code)	0)	
RAY MYERS / SON 5805 CAPITUL HEIGHT	TS MD 20743.		
20a. Method of Disposition    20a. Method of Disposition   Date			
LE de le le le le le le le le le le le le le	-2005 ARLINGTON	VA	
21. Smature of Funeral Service Licensee 22. Name and Address of Facility John			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re	espiratory arrest, Approxima	ite	
shock, or heart failure. List only one cause on each line.	Interval Be Onset and	tween Death	
/Medical resulting in death)  Due to (or as a consequence of):			
Examiner  Sequentially list conditions, b. It yes less than the sequence of th			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):			
pe to the cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
physician the buria the buria the buria the buria to open the buri			
So the second of	23d. Date of delivery  Month Day	Year	
O e tar tar tar tar tar tar tar tar tar tar	23e. Did tobacco use contribute to the cause of	death?	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Yes 2 No 3 Probably 4	Unknown	
s been s 2 should alw required alw required alw required always and always are always and always are always ar	24a. Was an autopsy findings prior to completion of comple	available	
The law requirements that the second cate has been spage 2 should completed	autopsy prior to completion of a death?  1 Yes 2 No 1 Yes 2 No	ause of	
25. Was case referred to medical examiner?  1			
2 ER/Outpatient 3 DOA William Home	5 Residence 6 Other (Specify)		
Natural 5 Pending (Month, Day Year) Injury Work?	. Describe how injury occurred		
1 Natural 1 Natural 2 No. 1 No	Location (Street and Number or Rural Route Num	nber,	
27. Manner of Death   Natural   28d.	City or Town, State)		
A A MARINE	due to the cause(s) and manner as stated.	s)	
29a. Certifier  Check only  29a. Certifier  Check only		/	
29a. Certifier  29a. Certifier	29d Date cinned (Month Day Vone)		
28e. Place of Injury · At home, farm, street, factory, office  28f. place of Injury · At home	29d. Date signed (Month, Day, Year)		
and manner stated.  29b. Signature and title of certifier  29c. License number  0 303/8	29d. Date signed (Month, Day, Year)		
and manner stated.  29b. Signature and title of certifier  29c. License number  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	29d. Date signed (Month, Day, Year) 4/12/05 VEVERLY MD 20786		

ysicia Nedica	n.	Decedent's Name (First, Middle, La	ast)				2. Date of De Month	-	3. Time of Death
//earci		Evelyn		McDow	e11			16, 2005	2337pm ^
amine	er	4a. Facility Name (If not institution, give	ve street and number)		4b. City, Town,	or Location of De	ath	4c. County of	Death
		6300 Foote St.  5. Social Security Number 6.3	Sex 7. Age (In yrs.	(act hiethday)	Seat P1	easant I Under 24 H	re   0 0 4 0 -	Prince	George's
eral ctor		-	1□M 2⊠F 55	Yrs.	Months Days	Hours M	in. Decembe		e. Birthplace (State or Foreig Country) Maryland
Let's		Usual Residence of Decedent  10a, State 10b, County						.1 27	
rollled at	٥	, , , , , , , , , , , , , , , , , , , ,		ity, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
and and and and and and and and and and	Director	DC  10e. Street and Number		lashingt	10f. Zip Code			10g. Citizen of Wha	
mustbe	a Di	312 60th Stree	t N.E.		20019	9		U.S.A	•
	by Funeral	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	If	Was Decedent of f Yes, specify Cub		(Specify Yes or No erto Rican, etc.)	- 14. Race - Black, Specify:	American Indian, White, etc. Black
	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Deced	lent's Usual Occu	pation	yorking	16b. Kind of Busin	ness/Industry
	mple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done OO NOT use retire	•	rorking		
-	Ŝ	12th 17. Father's Name (First, Middle, Last	1	Ent	repreneu		Inna (Fina Adidala	Priva	ite
- 1	To Be	Hobbie McDowe				Effic	lame <i>(First, Middl</i> e, 2	McDow	re11
1	F	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailin	g Address (Street	t and Number or	Rural Route Numbe		
		Carla Brooks/Da	aughter						Maryland2074
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Dispos cemetery, crem	sition (Name of natory or other pla	ace)	Date	20c. Location - Cit	
	-	`4 Donation 5 Other (Special			Nationa	, .	27/05	Laurel,M	•
SUCE.		21. Signature of Funeral Service Lice		71	6 Kenned	ly Street	t N.W. Wa	shington,	ns Funeral Ho DC 20011
п		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deal one cause on each line.	th. Do not ente	or the mode of dyi	ng, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between
n		Immediate Cause (Final disease or condition resulting in death)	a Dilated care						
al er					athy				Onset and Death
			Due to (or as a consec	quence of):		1	•	1.	
	er	Sequentially list conditions		quence of): e ather		cic card	iovascula	r disease	
	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consect	quence of): e ather		cic card	iovascula	r disease	
	Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consect	quence of):  e ather quence of).		cic card	iovascula	r disease	
	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Bue to (or as a consect b. Hypertensive to (or as a consect c.	quence of):  e ather quence of).		cic card	iovascula	r disease	
	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hypertensive  b. Due to (or as a consequence to (or a))).	quence of):  e ather quence of):		cic card	iovascula		
10.0	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	b. Hypertensive  b. Due to (or as a consequence of pregnature)  c. Due to (or as a consequence of pregnature)  1 Live birth 2 Feta	quence of):  e ather quence of):  quence of):  ancy al death 3 1	rosclerot		iovascula	r disease	
1	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	b. Hypertensive  Due to (or as a consequence)  C. Due to (or as a consequence)  d. 23c. If yes, outcome of pregnations and consequence (or as a consequence)	quence of):  e ather quence of):  quence of):  ancy al death 3 1	rosclerot		iovascula	23d. Date of	f delivery
Distriction (Market	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Due to (or as a consect by the to (or as a conse	quence of):  e ather quence of):  quence of):  ancy al death 3 to death 5 to death 5 to death	Ectopic pregnanc: Other (specify)	у		23d. Date of Month	f delivery
har Dharafalan Managan	by Physician/Medical	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	Due to (or as a consect by the to (or as a conse	quence of):  e ather quence of):  quence of):  ancy al death 3 to death 5 to death 5 to death	Ectopic pregnanc: Other (specify)	у		23d. Date of Month	f delivery Day Year
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 10:30 a. M Margaret Whaley McClung April 14, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) 1 ☐ M 2 👿 F Director Yrs 577-28-6226 Dec. 13, 1922 Washington, D.C. Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examinar must be notified at Director Maryland Montgomery Silver Spring 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 710 University Boulevard, West 20901 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No þ 3 ☐Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Omer Whaley Lottie Carder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i L. Neal McClung, Jr. / Son 714 University Blvd., W., Silver Spring, Maryland 20901 20a. Method of Disaesition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location · City or Town, State Date Pages 1 nent of H ant: If Ite April 15, permit. Page Department of Important: If any injury of once. Metropolitan Crematory Alexandria, Virginia \* 4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signa w of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Bilateral Pneumonia /Medical Due to (or as a consequence of) Examiner Interstitial Lung Disease Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the burial-transit Con estive Heart Failure that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Fortension use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d Date of delivery 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) the detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? þ pe Diabetes Type II, Rheumatoid Arthritis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown funeral director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 🗌 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No this 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by

The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records, Hospital or Attanding Physician: within 24 hours a To the Funeral D

Baltimore, Maryland 21215-0036

20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shahid Shamim, M.D., 31. Date filed (Month, Day, Year)

18 APR

4 | Homicide

(Check only onel 29b. Signature and title o

29a. Certifier

Medical

State

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D59284

29d. Date signed (Month, Day, Year)

April 14, 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 22:40 P M J. McCormack April 14, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice-Casey House Rockville

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖼 F Director Yrs. 579-26-6636 March 4,1924 Washington.DC Usual Residence of Decedent with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at once. Director 1 ☐ Yes 2 ☑ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 7009 Wolftree Lane 20852 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No 2 Specify: 3K Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>Administrative Assistant</u> Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Donato Bianchi <u>Ginnina</u> Masi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Son 12318 Sherwood Forest Drive John C. McCormack Mt. Airy, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 Donation 5 Dother (Specify) Apr. 16, 2005 Silver Spring, MD Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 · Ken Skile 23a. Rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Malignant Neoplasm; Liver, Primary resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, larry, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or se's consequence of): Examine physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy in the past 12 months?
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1 □ Yes 2 □ No autopsy performed? 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: 70 1 ☐ Yes 2 🙀 No 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification; 28d. Describe how injury occurred 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after deatl To the Funerel Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide pelli To the Hospitel Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Func 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 9 C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 6001 Muncaster Mill Road Rockville, MD Charles M. Harrison, 31. Date filed (Month, Da R 18 2005 32 Registrar's Signature State Registrar

			1 - For State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment of F		Mental Hy	/giene	005	14859	
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	7		30. Name and address of person wi	no completed cause of	death (Item 23a) (Type,				April 13, 2005			
			Alan R. Segal,	M.D. \J1517	Hugo Circ	le Silve	Spring	, MD 209	906			
	Stat Registra		31. Date filed (Month, Day, Year) APR 18	2005 Registr	rar's Signature	de						
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State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year APRIL 19, WILLIAM CHESTER MOSSER 2005  $A^{M}$ 4:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GARRETT COUNTY MEMORIAL HOSPITAL OAKLAND GARRETT 5. Social Security Number 8. Date of Birth Month, Day, Year) NOV 14, 1919 If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 10XM 2□F MARYLAND Director 218-16-3493 85 Vre Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exp. three must be notified at 1 X Yes 2 □ No Directo MD GARRETT OAKLAND 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5 E. MASON STREET USA 21550 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Itel 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No δ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION WORKER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EARL CLAYTON MOSSER MAUDE В. SPITZER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY MOSSER - WIFE 5 E. MASON STREET OAKLAND, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. GARRETT MEMORIAL GARDS 4/22/05 ` 4 ☐ Donation 5 ☐ Other (Specify) OAKLAND, MD 21550 21. Signature of uner | Service Lice 22. Name and Address of Facility P.O. BOX 243 Etalent M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RENAL FAILURE YEAR /Medical Due to (or as a consequence of) Examiner ARTERIOSCLEROTIC CORONARY VASCULAR DISEASE YEARS Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ed by the attending physician and detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 ∏Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Division of Vital 1 Yes 2)(2) No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Mnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ZX No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? e Hospital or Attanding Pl 24 hours after death. e Funeral Director: After th 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C 1 💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 in Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 H26154 APRIL 19, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 69 WOLF ACRES DRIVE P. DANIEL MILLER, D.O. OAKLAND, MD 21550 31. Date filed (Month, Pay, Year) APR 2 0 2005 32. Registrar's Signature State Registrar Di Aparte

			For	State of Mary	land / Dep	artment of h	lealth and M		_	11001
					Ce	rtificate of	Death		J. Nor UUD	14861
	Physici	an	Decedent's Name (First, Middle, I	Last)				<ol><li>Date of Death Month</li></ol>	Day Year	3. Time of Death
	/Media	cal	Alton Miller					April 1	9, 2005	2:29 a M
	Examir	ier i	4a. Facility Name (If not institution, g Goodwill Menno				r Location of Death		4c. County of Dea	
					yrs. last birthday	Grants  If Under 1 Year		9. Date of Birth	Garret	
	Funeral Director		186-32-2566 Usual Residence of Decedent	1 <b>⅓</b> M 2□ F	89 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, ) Sept. ]		thplace (State or Foreign ountry) Maryland
	land 10w		10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	Man Figh	ģ	PA Somers	et Sr	orings					1 ☐ Yes 2 No
	death with the Maryland ims 23a or 28a-f ehow if must be notified at	<b>Funeral Director</b>	10e. Street and Number	<u> </u>		10f. Zip Code		100	g. Citizen of What C	ountry?
	th wit	<u>=</u>	1959 Springs R	oad		15562			USA	
	dea	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No-	14. Race - Am	
ထ္	or It		1 Never Married 2 Married			1 ☐ Yes 2 ☐ No		nican, etc.)	Black, Whi	te, etc.
ğ	ural',	Completed by	3- Widowed 4 □ Divorced	Year or Dates:					Specify: W	hite
21215-0036	nati	ete	15. Decedent's (Specify only highest of		16a. Dece (Give	dent's Usual Occup kind of work done	ation during most of working)	ng 16	b. Kind of Business	/Industry
2	within ne. then	ם	Elementary/Secondary (0-12)	College (1-4or 5+)						
S B	Hygie ther int, II		17. Father's Name (First, Middle, La	st)	Owne	r/Opera	18. Mother's Name			Equipment
Maryland	ontal od o	Be	Norman Miller				Suie He			
Ξ	should d Me mark matic	ဥ	19a. Informant's Name/Relationship	(Type Print)	19h Maili	no Address (Street				Zip Code) 21536
<u>∞</u>	trau		Larry Miller/S		2158	Dorsey	Hotel R	oad. Gr	antevil	21536
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Introctant: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinet must be notified at Once.		20a. Method of Disposition						c. Location - City or	
٥	ages ant of ht: If i	20a. Method of Disposition  1  Surial 2  Cremation 3  Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  Springs Cemetery April 22,200								
Baltimore,	artme ortar injur	1	21. Signature of Funeral Service Lic		22	2. Name and Addre	ss of Facility Ne	wman Fi	neral H	omes, P.A.
Ba	Depa Impo any ir		Le Luche	umai -						
			23a. Pert1. Enter the disease, of co	mplications that caused the	death. Do not ent	ter the mode of dying	g, such as cardiac or	rantsvi respiratory arrest	lle, MD	Approximate
п			Immediate Cause (Final	ly one cause on each line.					-21	Interval Between Onget and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Well to (or as a con	cereno	Vascert	avacci	den		48 m
	Examiner			a thomas	se lom	5:5 - d	effere			Weeks
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	nsequence of):	J. J - ac	Dure			years
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	henre (	inido	nia				Years
o	te be executed ysician and le burial-transit		resulting in death) Last	Due (or as a con	nseq ence of):	THE STATE OF THE S				
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89	that the death certifica ed by the attending ph detached for use as th	Ned	IF FEMALE:						15	
X Q Q	th ce tendii r use	Physician/Med	23b. Was decedent pregnant	23c. If yes, outcome of pre		Ectopic pregnancy			23d. Date of de	
	e dea he at ed fo	slcl	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time 9☐ Unknown		Other (specify)			Month	Day Year
л О	at the	Phy	9 Unknown							
Hecords,	The law requires that the death certifica tite has been signed by the attending pr page 2 should be detached for use as the	þ	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	\ /	o the cause of death?  obably 4 □Unknown
ပ္တ	aw re s bee	plet						24a. Was an	24b. Were at	Itopsy findings available
Ĭ	The lav	Completed						autopsy performed	d2 death?	completion of cause of
Vital	an: rtifica tor, p	a	25. Was case referred to medical				26. Place of Death	(Check only one)	TWO   1 THIS	1 5 0
>	Physician: The la this certificate has ral director, page 2	To B	examiner?	Hospital: 1 Inpatient	2 ER/Outpatien	nt 3 DOA Oth		7.514.115	e 6 X Other (Spe	assisted
0	<u> </u>		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	r) 28b. Time of Injury	f 28c. Injun	at 2	8d. Describe how		J
DIVISION OF	Attending ir death. ector: After by the fune	Certification;	✓ Accident investigation	on	,,		Yes 2 □No			
Š	or Attend after death Director: #	ij	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		At home, farm, str	eet, factory, office	21	Bf. Location (Stree City or Town, S	t and Number or Ru itate)	ıral Route Number,
ב	ital o			<u> </u>						
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medicel Exe	Physician: To the best of my eminer: On the basis of exam and manner stated.	knowledge, death nination and/or inv	n occurred at the tim vestigation, in my of	ne, date and place, ar pinion, death occurred	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner stated.		29c. License	number	291	Date signed (Monti	n, Dav. Year)
	F 5 F ŏ		Marg. A	no King.	2 ^	7	16650		4/19/	2005
	2		30. Name and address of person who	ojcompleted cause of death (	Item 23a) /Turn-	Print)	2000		11/11/	000
	2		Marca volt a	Licor and	1307 (Type,	Garrott his	ahurur 1	volla	1 IIN.	11050
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature /	10000	ghwuy, C	ur will	$\eta$ , $M$ ) $a$	4550
	Registr		O APR Z 0	2005 Seem	N. A	and I				

State of Maryland / Department of Health and Mental Hygiene 14862 1 - For Stata Ragistra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Teresa Burdette Marquez /Medical April 17 2005 8:00p 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 502 Ridge Avenue Airy Mt. Carrol1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🗓 F Director Yrs 217-74-2592 48 Dec. 19, 1956 Maryland Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked othar than "natural", or items 23a or 28a-f ahow any injury or other traumatic avant, the Medical Exercities rount be notified an once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director TX□Yes 2□No Maryland | Carroll Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 502 Ridge Avenue 21771 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 27 No 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Estimator/Project Manager Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Allen E. Burdette Shelva Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen E. Burdette - Father Post Office Box 405, Clarksburg, Maryland 20871 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Ponation 5 ☐ Other (Specify) Bethesda Meth. Cemetery 4/21/05 Browningsville, Md. 5 Other (Specify) 21. Sign ture of Erneral Service Licens Name and Address of Facility Olin L. Molesworth P.A., Funeral Home vovert & 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Nonsmell cell C.L 4 month /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attanding Physician: The law requires that the death certiticate be executed Due to (or as a consequence of): Box 68760, attending physician Physician/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death Month Day Year 5 Other (specify) Division of Vital Records, P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' certificate 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Di scribe how injury occurred Affer 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Dev. Year) 120061040 April 18, 2005 MD 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. Rudin, MD 1650 Orleans Street CRB 344 Baltimore, Maryland 32. Registrar's Signature State 9 2005 Registrar

			For State Registrar	State of M	aryland			t of H	ealth a			•	05	1486	13
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	Funeral		5. Social Security Number	6. Sex 7. Ag		ast birthday)	If Under Months				Date of Birth (Month, Day,	Veer		place (State or Fitry)	oreign
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	Item Item	Funeral [	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	Armed Forces?		. 13.	If Yes, spec	ify Cuba	n, Mexican,	Puerto Ric	Yes or No- an, etc.)		ace · Americ lack, White,		
336	Jr. or	b	3 ∑Widowed 4 □ Divorced	If Yes Give			1 ☐ Yes 2	2⊠ No	Specify:			Spec	ify: LIF	nite	
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/lai	should be that Mental I s marked or umatic eve	10	William W. Moo	re					Eva M	Moore					
Maryland	2 sho and Is ma		19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address	(Street a	and Number	or Rural R	oute Number,	City or Tow	n, State, Zip	Code)	
	D = N = D		DeRonda M. Beall/ Daughter 11381 Canary Drive, I jamsville, Maryland 2175  20a. Method of Disposition (Name of Date 20c. Location - City or Town, State											21754	
Baltimore,	permit. Pages 1 am Department of Heall Importent: If item 2 any injury or other once.			3 ☐ Removal from State	ne of ther place	9)	Date 20c Location - City or Town State								
<u>Ë</u>	Pages ment of I ent: If its ury or o			1 Burial 2 Cremation 3 Removal from State  1 Onation 5 Other (Specify)  National Memorial Park 4/20/05  Falls Church, Virginia											
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<u>α</u>	es that the de gned by the a		Part II. Other significant condition	ons contributing to death b	ut not resul	ting in the u	nderlying ca	ause give	n in Part I.		23e. Did tob	acco use cor	ntribute to th	e cause of deat	h?
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Ö	after after Dire	Certification:	4  Homicide determ	building, et	c. (Specify)		,				City or Town,	State)			
	spits hours nere		29a. Certifier 1 Certifyir	g Physician: To the best	of my know	ledge, death	n occurred a	at the time	e, date and	place, and	due to the car	use(s) and m	nanner as sta	ated.	
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical	(Check only 2 ☐ Medical one)	Examiner: On the basis of and manner sta	examination	on and/or in	vestigation,	in my op	inion, death	occurred a	t the time, da	te and place	, and due to	the cause(s)	
	To the To the Comp	Σ	29b. Signature and title of certifie	r			29c.	License	number		29	d. Date sign	ed (Month, )	Day, Year)	
	,		the	en	_	1	. 1	100	25c	GP5	-3	41	12/	Lows	
	6		30. Name and address of person	who completed cause of d	eath (Item 2	23a) (Type,	Print)	, _		<u> </u>					
			Dr. Leszek Kar	owiec M.D. 5	01 No:	rth Fi	rederi	ick A	Avenue	. Gai	thersh	urg. N	Marv1s	nd	
	Sta		31. Date filed (Month (Par)	9 2005 32. Resistra	ar's Signatu	ire	- 4			400		ا و ع مد	y 10		
	Registr	ar		- 2003	MAS S	A A	See of	A. C. C. C. C. C. C. C. C. C. C. C. C. C.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Glenvile Albert Moreland April 2005 2:45 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Garrett County Memorial Hospital Oakland Garrett If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Min 15 M 2 ☐ F 236-12-9078 16, 1919 Director 86 Jan. West Virginia Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral, or items 23s or 28s-f show Examiner must be nutified at 1 ☐ Yes 2 N No Director Md Garrett Gorman 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 50 Alt House Hill Road 21550 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th Truck Driver Trucking permit. Pages 1 and 2 should be filed bepartment of Health and Mental Hygic Important: If Item 27 is marked other any injury or other traumatic event, Item 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Moreland Albert Issac Anna Ruth Jones ೭ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Cuppett/Daughter 1241 Collier Road, Accident, Maryland 21520 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4/15/2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Maysville Cemetery Maysville, WV 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 32 S. Second St. Stewart Funeral Home Oakland, Md. 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) acute myocardial infarction days **Physician** /Medical Due to (or as a consequence of): Examiner atherosclerotic heart disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed peripheral vascular disease years use as the burial-trans Due to (or as a consequence of): ed by the attending physician detached for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this activity. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1. Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas G. Johnson, M.D. 21550 311 N Fourth Street Oakland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature 8 2005 Registrar

		For State Registrar		State of Ma	aryland /	-	rtment of H tificate of I		Mental Hy	giene Reg. No. 2	005	11.05
Physicia		1. Decedent's Name Charles							2. Date of De Month April	Day 17	Year 2005	3:13 P M
/Medić Examin				street and number)			4b. City, Town, or	Location of Death			ty of Death	0.13
		Frederi	ck Memori	al Hospit	al		Frederi				deric	· <del>-</del>
Funeral Director		5. Social Security No. 216–38–10	064	57 M OF F	ie (In yrs. last b 63	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	th 1 <i>y</i> , Year) 7, 1941	9. Birthpl Count Mary	lace (State or Foreign try) Land
M. I	-	Usual Residence of 10a. State	Decedent 10b. County		10c. City, To	wn or Lo	cation				10	0d. Inside City Limits
de par	to	Maryland	Frederi	ck	M	ount	Airy					1⊠Yes 2□No
28e	Director	10e. Street and Nun	nber				10f. Zip Code			10g. Citizen o	f What Coun	itry?
23a c		104 Pla	ainview A	venue				21771			ted St	tates
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28e-f show important: If item 27 is marked other than any injury or other traumatic event; the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Marri 3 ▼Widowed	ed 2 Married 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Vas Decedent of H f Yes, specify Cuba I □ Yes 2⊠ No	ispanic Origin? (S in, Mexican, Puert Specify:	pecity Yes or No o Rican, etc.)	Spec	ace - Americ ack, White, e afy: White	
nd Mental Hygiene. I marked other than "natural", or items 23s or 28s-f show umatic event. The Medical Examinar must be indiffed at	Completed	(Spec	15. Decedent's Ed ify only highest grad ndary (0-12)			(Give life. l	lent's Usual Occup kind of work done o OO NOT use retired	during most of wor	rking	16b. Kind of		
tygier ther th		17. Father's Name (	(First Middle Last)			Car	penter	18. Mother's Nar	na (First Middle		struct	tion
sontal k ked of c eve	o Be		n McVey					Nora	Unkn			
mark umati	ř.		me/Relationship (7	ype, Print)	19	9b. Mailir	g Address (Street				n, State, Zip	Code)
alth a		Roxanne	Gue / Da	ughter			Westward	Court M	It. Airy	, Maryl	and 2	1771
of He If item or oth		20a. Method of Disp		Removal from State	20b. Place cemet	of Dispo tery, cren	sition (Name of natory or other plac	(Apri	Date 1 20	20c. Location	- City or To	wn, State
tant: tant: jury c		` 4 □ Donation	5 Other (Specify	)	Calva		Baptist C		1 20, 2005,	Mt. Ai:		
Depar Impor any in		21. Signature of Fu	rieral Service Lices	500			Name and Address E. Ridge					es, P.A. and 21771
hysician Medical		23a. Part1. Enter the shock, or heat Immediate Cause (disease or condition resulting in death)	rt failure. List only ( Final	a	d the death. Do	100	er the mode of dyin	g, such as cardiad	or respiratory a	etian	)	Approximate Interval Between Onset and Death
e attending physician and use as the burial-transit	edical Examiner	Sequentially list con if any, leading to hi cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	irlying injury	с	a consequence							
e attendir ad for use	Physician/Mec	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)	,			Date of delive	ery Day Year
n signed by uld be detac	by	Part II. Other signif	icant conditions of	ontributing to death b	out not resulting	in the u	nderlying cause giv	en in Part I.	23e. Did 1			e cause of death? ably 4 \( \sum \text{Unknown} \)
cate has been signed by the	Completed	V							24a. Was auto perfo 1 🗆 Yes		. Were autor prior to cor death? 1 \( \text{Yes}	psy findings available inpletion of cause of 2 No
r this certificate ral director, pag	Be	25. Was case refer examiner?		Hospital:			Oth	or	ath (Check only			
th. After this funeral dii	tion: To	1 ☐ Yes 2 ☐  27. Manner of Deat  1 ☑ Natural  2 ☐ Accident		28a. Date of Inju		Dutpatien  Time of Injury	28c. Injur Wor	4 ∐ Nursing P	lome 5 Res 28d. Describe	how injury occi		/)
within 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral di	Certification:	3 Suicide 4 Homicide	6 Could not be determined	280. Place of th	jury - At home, tc. (Specify)	farm, str	eet, factory, office			Street and Nun wn, State)	nber or Rura	l Route Number,
e Funer letely fill	edicai	29a. Certifier (Check only one)		ysician: To the best niner: On the basis of and manner st	of examination							
withir To th comp	Me	29b. Signature and	vitle of certifier	1			29c. Licens	e number		29d. Date sign	ned (Month, I	Day, Year)
7		30_Name and addr	ess of person who	completed cause of	Note that the death (Item 23a	1) (Type,	$\mathcal{D}_{\mathcal{C}}$	1839	/	4-	17-	05
		SAJJ7 31. Date filed (Mon	TO A=	212,ME	rar's Signature	01	Toll	House	Ave	Fred	lerie	6,MD
Sta Registr		J. Sato mad (MON	APR 19	2005	Bee 1	× A	Sand J					21401

State Registrar

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	_	1 - For State Registrar	otato of maryta	•	rtificate of L			g. No. 0	5 14866
		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
Physicia /Medic	_	Phyllis Chlo	e Masor	1_					Year 005 10:51 A M
Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death	1	4c. County	of Death
		Frederick Memoria		lant hinthday	Frede	rick If Under 24 Hrs.	O. Date of Birth	Fre	derick
Funeral Director		5. Social Security Number 6. Sex 1□	M OFF	. iast birthday) 18 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, June 27,	Year) 1926	9. Birthplace (State or Foreign Country) Maryland
		Usual Residence of Decedent					Julie 27	1720	maryranu
hyjan show	ı.	10a. State 10b. County	10c. C	ity, Town or L	ocation				10d. Inside City Limits
he Ma 18a-f	Director	Maryland Frederic	c	Fred	erick				1 X Yes 2 □ No
with the a or 2	Dir	10e. Street and Number	_		10f. Zip Code	21702	10		What Country?
at yearlied Z. Z. Z. Z. Z. Z. Z. Z. Z. Z. Z. Z. Z.	Funerai	1421 Taney Avenue	2. Was Decedent Ever in U	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-		ed States ee - American Indian,
or iter	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Puerte Specify:	o Rican, etc.)	ł	ck, White, etc. v· White
72 hours aft	d by	3 ☐ Widowed 4 ☒ Divorced	Year or Dates:			. ,		Specify	y; WIIILE
be filed within 72 ho tal Hygiene. natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wor	king 1	6b. Kind of B	usiness/Industry
withir ene.	duc	Elementary/Secondary (0-12)	College (1-4or 5+)		memaker	,		Own	Home
filed Hygi other	a)	17. Father's Name (First, Middle, Last)			memaker	18. Mother's Nam	ne (First, Middle, M		
Aenta Aenta rked tic ev	To B	Robert K. Mason				Willet	t Lang		
2 should be filed within and Mental Hygiene. Is marked other than eumatic event, Item M.		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Maili	ng Address (Street a	and Number or Ru	ral Route Number,	City or Town,	State, Zip Code)
and and man an		Victoria Brady / Da			Newport T				land 21701
ges 1 tof H if it its		20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐ Re	emoval nom State		osition (Name of matory or other place	ADL	111,		City or Town, State
it. Pa intmen intenti injury		' 4 □ Donation 5 □ Other (Specify)  21. Signature of runeral Service License			k Cremator		2005 I	rederi	ck, Maryland
permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any Injury or other treumatic enonge.		12001t		11	621 Opossi	mitown Pi	auffer Fu ke Fred	meral erick.	Homes, P.A. Maryland 21702
Mary Carro		23a. Part1. Enter the disc ase, or complice shock, or heart failure. List only on	cations that caused the dea						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Pneumothora	v					Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conse						
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red	nine	Tany, landing to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a conse	Qualities ()					
be executed sician and burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as a conse	quence of):					
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attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1☐Live birth 2☐Fet 4☐Pregnant at time of	al death 3	Ectopic pregnancy			1	te of delivery onth Day Year
the de	ıysic	1 □ Yes 2 XNo 9 □ Unknown	9□ Unknown	0 <del>0</del> a(() 5)	Other (specify)				
The law requires that the death certificate is the has been signed by the attending physicage 2 should be detached for use as the t	by Ph	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	inderlying cause give	en in Part I.	23e. Did tob	acco use cont	ribute to the cause of death?
w requires		Pneumonia, Sepsis	3				1 X Ye	s 2□No	3 ☐ Probably 4 ☐ Unknown
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ysician: The rise certificate director, pag	Be (	25. Was case referred to medical examiner?	oppital:		Otho		th (Check only one		
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ding Phy th. After thi	tion	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Work	(? Yes 2 □ No		· injury coour	
Attendary death or death or death or death or by the	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At I	nome, farm, st	reet, factory, office		28f. Location (Str. City or Town,	et and Numb	per or Rural Route Number,
tel or s efte el Dir	Certification:	4 Difficide	building, etc. (Speci	ny)			City of Town,	State)	
To the Hospital or Attending within 24 hours eller deals to the Funerel Director: Attending completely filled in by the funer	edicai	29a. Certifier 1 To Certifying Physics (Check only one) 2 Medical Examin	ician: To the best of my kn er: On the basis of examin	owledge, deat ation and/or in	th occurred at the time execution, in my op	ne, date and place pinion, death occur	, and due to the car rred at the time, da	use(s) and ma te and place,	anner as stated. and due to the cause(s)
o the vithin 2 o the	Mec	20h Signature and title of certifier	and manner stated.		29c. License	number	29	d. Date signe	d (Month, Day, Year)
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١		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type,		-			,,
		Lalit M. Verma, N			h Street	Frederi	ck, Maryl	and 21	701
Sta Registr		31. Date filed (Month, Day, Year) APR 1 9 2	32. Redistrar's Sign	ature	mod)				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** APRIL 13, 2005 WILLMA LEE 5:03 AM NEELY /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Brooke Grove Nursing & Rehab Ct MONTGOMERY Sandy Spring 8. Date of Birth (Month, Day, Year) June 2,1923 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
S. Carolin 5. Social Security Number **Funeral** Days Months 1 □ M 2XCXF Yrs. 240-60-2528 Carolina Director Usual Residence of Decedent parmit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Dapartment of Health and Martal Hygians. Important: If item 27 is marked other than "natural", or items 23a or 100.000. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits XXYes 2□No Directo MD Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18130 Slade School Road 20860 U.S.A. 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√ No Specify: Specify: Black \$ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Factory Worker Cellanese Prod l yr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Wilks Elnora Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bill Neely (Son) 1305 Mimosa Lane, Silver Spring, MD 20904 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (vianue or commence, cernatory or other place)

11. Vernon Presyterian 4/18/05 NG Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodleaf, NC Church Cemetery 22. Name and Address of Facility Snowden Funeral Home, P.A. 21. Signature of Funeral Service Licensee 246 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** Wedical Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction hours Examiner Examiner The law raquiras that tha death certificate ba axecuted attending physician and I for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): this certificata has been signad by the raid irector, paga 2 should be datachad it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown Denentia \$ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 ☐ Yes 2 10 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours aftar daath.

To the Funeral Director: After this certifica completaly filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death | Check only one | examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Aursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 No 27. Manner of Death 28d. Describe how injury occurred Certification: Vatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier Descripting Physician: To the best of my knowledge, death conumed at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Physician 15,2005 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd alney, MI) 20832 Olney-Leytorsville MATHUR 4000 ALOK 3 Registrar's Signature 31. Date filed (Month, Day, Year) State 18 Registrar

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Ma	arylan		artmen tificate			and M		giene Reg. No.	005	14868
	Physici	an	Decedent's Name (First, Middle, I  DEBRA	•			NT ON O	T C			2. Date of Dea	Day	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, g	ROSE			NICHO 4b. City,		Location o	of Death	APRIL	12 4c. C	2005 ounty of Dea	6:10 P M
	LAdiiii	CI	71 BRASSIE COU						RY VI		E		MONTGO	
	Funeral Director		214-78-9834	. Sex 7. Ag 1 ☐ M 2 X F	e (In yrs. 48	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min	8. Date of Birt (Month, Day DEC • 2	195	9. Bir CON	rthplace (State or Foreign ountry) NNECTICUT
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	a-fsh	ctor	MD MONTGO	OMERY			MONT	GOME	RY VI	LLAG	E			1 ☐ Yes 2 🔀 No
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	s 238	erai	71 BRASSIE COU	12. Was Decedent	Cuarin II	c   12 l	Man Daged		886	-1-2 (C-		4.4	USA	
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21215-0036	72 hor	Completed	15. Decedent's (Specify only highest of	Education		16a. Deced	lent's Usua	l Occupa	ation	of worki	20	16b. Kind	of Business	
2	within ene. then "	mpie	Elementary/Secondary (0-12)	College (1-4or 5	5+) ~		kind of wor DO NOT us			OI WOIKII	<i>'</i> 9			ED ARMY
2	e filed value Hygie other t		12 17. Father's Name (First, Middle, La	st)		FIIN	ESS D	TREC		r's Name	(First, Middle,		CAL CE	ENTER
Maryland	2 should be and Mental Is marked o	To Be	ALBERT GAULT  19a. Informant's Name/Relationship	0		10b Mailin	a Address	(Street -	NORM	1A (	QUINTO		·	7.0.11
Z	and 2 si salth an n 27 Is r		ROY R. NICHOLS				RASSI				<i>l Route Numbe</i> GOMERY			D 20886
re,	s 1 and 2 of Health item 27		20a. Method of Disposition		20b. P	lace of Dispo emetery, cren	sition (Nam	e of			ate			Town, State
altimore,	nit. Pages bartment of ortant: If i injury or		1 ☐ Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Special	Removal from State		LINCOL	-			/18/	′2005 I	BRENT	WOOD,M	1ARYLAND
Balt	permit. Pages Department of H Important: If ite eny injury or of		21. Signature of Funeral Savive Lio	nsee	-		Name and	d Addres NEW	s of Facility HAMPS	HIN HIRE	ES-RINA AVE. S	LDI	FUNERA R SPRI	L HOME, INC.
8760,	death certificate be executed  Exam  Medical  Be attending physician and dir use as the burial-transit	icai Examiner	23a. Part 1. Enter the disease, or co chock or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Ente. Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. METASTAT  Due to (or as  b. LEFT BRE  Due to (or as  c	TC E a consequ EAST a consequ	REAST uence of): CANCER uence of):			, such as c	earthac 0	respiratory an	951,		Approximate Interval Between Onset and Death  7 years
.O. Box 68	the death certify the attending chad for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pre Other (spe					230	d. Date of del Month	livery Day Year
rds, P		by	Part II. Other significant conditions	contributing to death bu	ut not resu	ulting in the ur	iderlying ca	iuse give	n in Part I.					o the cause of death?
Records,	The law requires ate has been sign page 2 should be	Completed									24a. Was a autops perform	sy med?	24b. Were au prior to death?	utopsy findings available completion of cause of
Vital	icien: Th certificate rector, pag	0	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only or	2 <b>X</b> No	1 🗀 185	2 No
of	Phys rathis ral di	ion; To B	examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	ry	ER/Outpatien 28b. Time of Injury		c. Injury Work	4   Nur	. 2	ne 5 y Reside 8d. Describe he			cify)
Division	ten leat tor: the	Certification;	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be One Place of Inju	ury - At ho c. (Specify	me, farm, stre			33 201		8f. Location (Society or Town		Number or Ru	ural Route Number,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical (	29a. Certifier X Certifying I (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examina	wledge, death ion and/or inv	occurred a estigation,	it the time	e, date and inion, death	l place, a h occurre	nd due to the c d at the time, d	ause(s) an ate and pl	id manner as ace, and due	s stated. to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certified	c 15	2	. V2	29c.	License	number		. 2	9d. Date s	signed (Monti	h, Day, Year)
	<		Jose de Le	on oup	w	A	3	D005	58844			APRI	L 13,	2005
	-		30. Name and address of person wh	1	-		•	7C D*	ZIBY C	ED344	TELOTE -			
	Sta	te	JOSE DE LEON CA		or's Signat	INECA M	LEAUOW	IS PE	CWY GI	<u>LKMA</u>	NTOWN,M	ARYLA	ND 208	376
	Registr	4	APR 18	2005 France	w s	s Ap	MALE							

	_	For State Registrar		aryland / Depa		Health and N	/lental Hygi	•	14869
Physicia /Medica	n al	1. Decedent's Name (First, Middle, Last Arrington Lee	Price				2. Date of Death Month April	8, 2005	3. Time of Death 8:00A M
Examine Funeral Director		4a. Facility Name (If not institution, give 5802 Ottawa St 5. Social Security Number 6. Se 224-52-9900	reet	o (In yrs. last birthday)		Height: Height: Hours Min.	8. Date of Birth (Month, Day, 3-16-1	4c. County of Death Prince G  Year) 9. Birthp County VA	eorges  Place (State or Foreign  Place)
within 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28e-f show its Medical Energiner must be tradified at	Director	Usual Residence of Decedent  10a. State 10b. County  MD P.G.		10c. City, Town or Lo	eights			1	0d. Inside City Limits 1⋤Yes 2☐No
s 23a or 2		10e. Street and Number 5802 Ottawa St	reet	Type in II C	10f. Zip Code 20745			U.S.A.	
ours after d	בַ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  XXYes 2 N If Yes, Give Year or Dates:	。1967 '	was Decedent of the fixes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Bla	etc.
within 72 hr iene. then netu	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		+)	dent's Usual Occup kind of work done DO NOT use retire	pation during most of work d)	ing 1	6b. Kind of Business/Ind	dustry
Mal ylailla AIAI9-0030 to 2 should be filed within 72 hours att th and Mental Hygiene. 27 is marked other than "neturel", or -treumetic event, the Medical Estria	lo Be C	17. Father's Name (First, Middle, Last)  John Price Sr.				18. Mother's Name	e (First, Middle, M nia Cla	aiden Sumame) rk	
1 C, Ivical s 1 and 2 sh f Health and item 27 is m other treum		20a. Method of Disposition	rife		Ottawa	St.For	est Hei	City or Town, State, Zip ghts , Md . 2 0c. Location - City or To	0745
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28e-f show any injury or other treumetic event, the Medical Examinar must be indifficated.	ſ	1 Burial 2 XCremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens		Riverdal	e Crema	tory	odges a	Riverdal nd Edward itland,MD	
ite be nysicia ne bu	Ical Examin	23a. Pant. Enter the disease, or complete Spock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and a subject of the cause of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Squamou Due to (or as a	е.					Approximate Interval Between Onset and Death 2yrs7mon
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wrequires that been signed b should be deta		Part II. Other significant conditions cor	ntributing to death bu	t not resulting in the un	iderlying cause giv	en in Part I.		cco use contribute to th	e cause of death?
sicien: The law requir certificate has been si irector, page 2 should							24a. Was an autopsy performe 1 ☐ Yes 20	prior to con	osy findings available inpletion of cause of 2 No
ig ig p	0	25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No  27. Manner of Death 1 ☒ Natural 5 □ Pending	fospital: 1  Inpatien 28a. Date of Injury (Month, Day	28b. Time of	28c. Injur	ce 6 ⊡Other (Specify	)		
or Atten after dea Director in by the	Cermican	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home, farm, stre (Specify)		Yes 2 □ No	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
the Hospi iin 24 hou the Funer pletely fill	- alcai	29a. Certifler (Check only one)  2 Medical Examination one)  29b. Signature and title of certifler	sician: To the best of ner: On the basis of a and manner state	examination and/or inv	occurred at the timestigation, in my o	oinion, death occurre	ed at the time, date	se(s) and manner as state and place, and due to	the cause(s)
T T T T T T T T T T T T T T T T T T T		1 Sanpte	mpleted cause of de	ath (Item 23a) (Type, F	D43	346	4	Date signed (Month, D	
State		RUTA GUPTA 31. Date filed (Month, Day, Year)  APR 1 9 2005	3 Registrar	1926 NO	ODYARI	KOAD	#201	CLINTON	My 20735

			For State Registrar	State of		d / Depa	artment of his	Health and			2005	11.870
			1. Decedent's Name (First, Middle,	Last)					2. Date of D Month			3. Time of Death
	ysicia Nedic		AL D. PAI						April	13		3:25 P M
	amin		4a. Facility Name (If not institution,	give street and nun	nber)		4b. City, Town, o	or Location of Dea	ath	4c.	County of Death	
			1909 South Fal				Potoma				Montgome	ry
	eral		,	5. Sex 1 🖾 M: 2 🗆 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		n. (Month, D	ay, Year)	9. Birthp Cour	place (State or Foreign
Dire		-	555-88-5767 Usual Residence of Decedent		64				Sept.	17,1	940 Sout	h Korea
land	10	Ì	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				1	0d. Inside City Limits
Mary -1 eh	T I	ţ	Maryland Montgo	merv	Po	otomac						1K Yes 2 □ No
r 28e	The state of	lrec	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Cour	ntry?
h with	2	Funeral Directo	1909 South Fal	lsmead Wa	У		20854			U.	S.A.	
deat	3	ner	11. Marital Status	12. Was Dece Armed Fo	dent Ever in U	.S. 13.	Was Decedent of h	Hispanic Origin?	(Specify Yes or N		14. Race - Americ	
after or its	8	/Fu	1 ☐ Never Married 2 ☑ Marrie		2 🔀 No		1 □ Yes 2 🖾 No		ano moan, etc.,		Black, White, Specify: Asia	
d within 72 hours af giene. yrthan "natural; or	E	d by	3 Widowed 4 Divorced	Year or Da								
72 t	9	Completed	15. Decedent's (Specify only highest			16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during most of w	orking		ind of Business/In	. 1
Mithir L	N N	ш	Elementary/Secondary (0-12)	College (1	-4or 5+)	1	cesident	(d)			nitorial/	
Hygie ther	f.	e Co	17. Father's Name (First, Middle, L.			[ F1	esident	18. Mother's N	ame (First, Middle			Services
yland  uld be file  Mental Hy arked oth	C eVe	00	Yong Chul	Pai				Jung	Mai Le			
and Me	mati	ို	19a. Informant's Name/Relationshi			19b. Mailir	ng Address (Street				r Town, State, Zio	(Code)
Mich nd 2 sh lth and 17 is m	rtreu		Kathy B. Pai/W	ife								and 20854
ten a G	ette		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of matory or other pla		Date Date		cation - City or To	
ages antol	\$0		1 ☑ Burial 2 ☐ Cremation :  4 ☐ Donation 5 ☐ Other (Spe				Memorial		15/2005	01n	ev Marv	land
DESIGNATION CE, INTERVIENT C L L 2 - DUGO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or items 23e or 28e-f ehow	흔		21. Signature of Funeral Service Li		1		2. Name and Addre					Land
	£ 8		Name A	Variance and	_ t.	, H.	LNES-RINA 1800 New	ALDI FUNI	ERAL HOM	E, II	VC.	MD 20904
Physic /Med			23a. Part1. Enter the discusse, or of shock, or heart fill List of Immediate Caus. Final disease or condition resulting in death)	nly one cause on e	ach line. Static	h. Do not ent Biliar	er the mode of dying	ng, such as cardi	ac or respiratory	arrest,	T OPTIME	Approximate Interval Between Onset and Death
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		P.	Sequentially list conditions, if any, leading to immediate	b. Due to (	or as a conseq	uence of):						
ited	insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause to sease or injury	•								
oU, be executed ician and	ial-tra	Exa	that initiated events resulting in death) Last	c Due to (	or as a conseq	uence of):						
icate be executed physician and	ing e	cal	1	d								
Certificate	as th	Med	IE ECHALE.			. 2000				-		nersen
COLOS, P.O. BOX OR wequires that the death certifica been signed by the attending ph	r use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna		Ectopic pregnanc	v		4	23d. Date of delive	*
o death death he atten	of be	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregna 9☐Unkno	ant at time of d		Other (specify)				Month	Day Year
at the J	etach	Phy	9 🗆 Unknown						14			
The law requires that the has been signed b	pe q	by	Part II. Other significant condition	s contributing to de	ath but not res	ulting in the u	nderlying cause giv	en in Part I.				ne cause of death?
ord requir	plnou	ted							10	Yes 2	No 3 Prob	ably 4 Unknown
HECOT he taw requ	22 85	ompleted							24a. Was	psy	prior to cor	psy findings available inpletion of cause of
	page	Cou							perf	ormed? 2 ☑ No	death?	2 🗆 No
VICAL PRINCIPLE TO CONTINUE TO	director,	Be	25. Was case referred to medical examiner?						eath (Check only			
Of VICE Physicien: this certific	al dire	2	1 ☐ Yes 2 🔼 No			ER/Outpatier					G ☐ Other (Specify	"
ffer ng	nu	- Co	27. Manner of Death 1 ☒Natural 5 ☐ Pending		of Injury h, Day Year)	28b. Time of Injury	Wor	rk?	28d. Describe	how injur	y occurred	
Attending r death.	by the t	cat	2 Accident investigated as Suicide 6 Could no	t he	- 6 let 61 l			Yes 2 □No	005 1	(0)	(1) 1 0	
JIVISIO I or Attendi after death. Director: A	in by	ertification:	4 ☐ Homicide determin	ad 286. Place	of injury - At no	ome, farm, str	eet, factory, office		City or To	wn, State	d Number or Rura )	Route Number,
pitel purs a	pellij	0	29a. Certifier 1⊠ Certifying	Physician: To the	host of my know	włodao dosti	2 Oppured at the time	mo data and alac	a and due to the	221122/21		
Hos 24 hc Fun	ətəly	edical		kaminer: On the ba and manr	isis of examina	tion and/or in	vestigation, in my	ppinion, death occ	curred at the time,	date and	place, and due to	the cause(s)
DIVISIO  To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A	completely filled in	Me	29b. Signature and title of certifier	7-11			29c. Licens	se number		29d. Dat	e signed (Month,	Day, Year)
	/		1	///			DC MT	33109		Apr	il 14, 20	005
2	7		30. Name and address of person w	ho completed caus	e of death (Item	1 23a) (Type						
			Jimmy Hwang, M	/	Reservo	ir Roa	d, NW, Wa	ashingto:	n, D.C.	2000	7	
	Sta	te	31. Date filed (Month, Day, Year)		egistrar's Signa	ture	. 10. 0					
Re	gistr	ar	APR 182	UUD BU	egistrar's Signa	Goa						

الكريت التي	س	1 - State Registrar		Ce	ertificate of l	Death	- <del></del>	g. No. 4 U	12 118
hysicia	an	<ol> <li>Decedent's Name (First, Middle, La Veronika Prauli</li> </ol>					2. Date of Deat Month	Day	3. Time of Dea
/Medic					th City Taylor			14, 2005	12:30 a
xamin	er	4a. Facility Name (If not institution, giv			4b. City, Town, or		1	4c. County of	
	-	National Luthera  5. Social Security Number 6. S		(In yrs. last birthday	Rockvi	If Under 24 Hrs	8 Date of Birth		Montgomery
neral ector		213-40-8080	1 M 2 XF	88 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan. 28,	Year) 1917	9. Birthplace (State or For Country) Latvia
<b>*</b>	1	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Lin
S E	ō	Maryland Montq		•	cville				1 ☐ Yes 2 ☐
. E 88	Director	10e. Street and Number	J		10f. Zip Code		1	0g. Citizen of Wh	
28 01									
2 8 2	Funeral	9539 Viers Drive	12. Was Decedent Ev	ver in U.S. 13.	. Was Decedent of H If Yes, specify Cuba		pecify Yes or No-	USA 14. Race	- American Indian,
- H	Fur	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 🔯 No				o Rican, etc.)	Black,	White, etc.
d other than "netural, or tems 23s or 28e-1 snow event, the Medical Exact har must be multified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2⊠ No	Specify:		Specify:	White
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other than vent, the Mu	S	12			Homemaker				n Home
d of	e	17. Father's Name (First, Middle, Last	")				ne (First, Middle, M		)
atc	၉	Antons Nitish					ga Nitish		
E E		19a. Informant's Name/Relationship (			ling Address (Street a				
m 27 her ti		Edmunds Praulins,	Sr./Husban	The second secon	The second	ive, #2,			land 20850
rient: if item 27 is marked		20a. Method of Disposition 1    2 Cremation 3 □	Removal from State	20b. Place of Disp cemetery, cre	position (Name of ematory or other plac	e) Apr	il 19,	20c. Location - C	ity or Town, State
lury (	١,	' 4 □Donation 5 □ Other (Special	fy)	Rock Cr	eek Cemet	ery 2	005 V	Vashingt	on, DC
any of		21. Signature of Funeral Service Lice	g\$66	F	22. Name and Addres	ss of Facility ins	Funeral	Home In	С
드립리		The D	Der	10 5	00 Univer	sitv Blv	d. W. Sil	ver Spr	ing. MD 209
ician dical niner		23a. Part Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Dua to (or as a	onseq¶, nce ou		g, Juch as cardia	or respirator, arre	ment re	Approximate Interval Betweek Onset and Deat
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			partment of Health and Mertificate of Death	•	2005 14872
Physi	ician	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year 3. Time of Death
/Med	dical	Lucille E. Rosenberry	4h City Town as Location of Doub	april i	9 2005 6:40 AM
Exam	niner	Washington County Hospital	4b. City, Town, or Location of Death		4c. County of Death
Funera	al	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Hagerstown  J If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	Washington  9. Birthplace (State or Foreign Country)
Directo	or	175-03-2464 1 M 2 K F 87 Yrs.  Usual Residence of Decedent	World's Days Hours Will.	10/15/19	17 PA
show		10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits
e Man a-fsh	ç	MD Washington Hage	rstown		1X Yes 2 □ No
ith the M or 28a-f	Funeral Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
eath v	23	13813 Marsh Pike	Was Deceded of Hispania Origin? (Spe		USA
fter d	H.	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - American Indian, Black, White, etc.
72 hours after death w "natural", or Items 23a	2	3XXVidowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: WHITE
natu edica	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Given the complete of the complete o	edent's Usual Occupation e kind of work done during most of working	ng 16t	o. Kind of Business/Industry
withly iene.	9	Elementary/Secondary (0-12) College (1-4or 5+) OWI	NER /OPERATOR	R	uilding and Real Esta
Video in the Maryland Maryland Mental Hygiene Hygiene arked other than "natural", or Items 23a or 28a-f show attle event, the Medical Examinat must be notified at	B C			(First, Middle, Mai	
should be filed withir and Mental Hygiene. marked other than umatic event, tha M	Ę	Benjamine Rotz	SARA	BLLLF U	ENHERR
2 8 8 8			ling Address (Street and Number or Rura		ALEX C. DESIGNATION
ss 1 end 2 should of Heelth and Mer item 27 is marker other traumatic		20a. Method of Disposition 20b. Place of Disp	Menno Village, Cha		PA 17201 Location - City or Town, State
Pages ent of nt: if i		1 XBurial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Parklaw	Memorial 4/22/		nambersburg, PA
permit. Pages 1 Depertment of H Importent: if ite	once.				s Funeral Home
	a	Jally Lee Davis M01414	12525 Bradbury Ave.	. Smithsb	ury, Maryland 21783
	9	220 P. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	2	r respiratory arrest,	Approximate Interval Between Onset and Death/
Physicia: /Medica	_	Immediate Cause (Final disease or condition resulting in death)  a. ### ### ###########################	Pheumoma		ineek.
Examine	_	Due to for as a consequence of):	Preumonia roententis		
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ecuter and -trans	Examiner	Cause (Disease or injury that initiated events c			
cate be executed physician and the burial-transit	E E	Due to (or as a consequence of):			
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Physician: The law requires that the death certificate be executed this certificate has been signed by the ettending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1	☐Ectopic pregnancy		23d. Date of delivery
the et	io a	in the past 12 months?  1	Other (specify)		Month Day Year
that the ed by detac			underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
requires (	>d be		Wellitus 2	1 ☐ Yes	2 Solo 3 □ Probably 4 □Unknown
law requir as been si 2 should I	piet	Atherosclarotic Vas ala	u Diseuse	24a. Was an	24b. Were autopsy findings available
sician: The law sicertificate has birector, page 2 si	Completed	Essential Hy neutrus in		autopsy performed 1 Yes 2	prior to completion of cause of death?  No 1 Yes 2 No
iclan: certific ector.	B	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
Phys r this	Ę	To res 20 No		ne 5 Residence	e 6 Other (Specify)
nding ath. r: Afte e fune	ation a	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)  27. Injury  28b. Time (Month, Day Year)			.,,
r Atte er de: recto	Certification	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number,
oltel o urs eft rel Di					
Hosy 24 ho Fune stely f	polical	29a. Cartifier (Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the caused at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the Hospitel or Attending Physician: The within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director.	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
		· May & Molly 16)	023815	19	pri/19 2005
		30. Name and address of person who completed cause of death (Item 23a) (Type Wary & Money, m.D. 354 Mil	Specker  Specker  Specker	en ins	21740.
S Regis	State strar	31. Date filed (Month, Day, Year)  APR 2 0 2005  32. Registrar's Signature	Speke .		

			Please	State of Ma	aryland / De					-	•	Die.		
			1 - For State Registrar	Otato or int		ertificat			trica iv		eg. 200	5	148	73
	Dharini		1. Decedent's Name (First, Middle, Last	)						2. Date of Dea Month		Year	3. Time of	Death
	Physici /Medio		DANIEL ARTHUR	ROHRER S	SR.					April	18, 20	05	8:20	РМ
	Examir	er	4a. Facility Name (If not institution, give			4b. City,		Location of			4c. County		OTTON T	
	Funeral		REEDERS MEMORIAL I 5. Social Security Number 6. Se		e (In yrs. last birthda		1 Year	ONSBOI	24 Hrs.	8. Date of Birth (Month, Day		SHIN 9. Birth	JION place (State ontry)	or Foreign
	Director		215-36-6879	M 2□F {	39 Yrs	Months	Days	Hours	Min.	JUNE 21	, Year) , 1915		RYLAND	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location			··· •				10d. Inside Ci	ity Limits
	Maryl	tor	MARYLAND WASHIN	GTON			BO	ONSBO	RΩ				1 🗌 Yes	•
	in the	Directo	10e. Street and Number	01011		10f. Zip		OHDDO	110	1	0g. Citizen of \	What Cou	ntry?	
	eth wi		6724 WHEELER ROAD					21713				U.S.		
	itame	Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 📉 N		3. Was Deced If Yes, spec	ent of Hi	ispanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		e - Ameri ck, White,	can Indian, etc.	
3-003p	J within 72 hours after deeth with the Maryland plene. I then "natural; or Itama 23s or 28s-f ehow Itte Medical Examination must be motified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2 <b>X</b> No	Specify:			Specify	·· WHI	ITE	
ည်	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	(G	cedent's Usua ive kind of wo	rk done a	lurina most	of work	ing	16b. Kind of B	usiness/In	dustry	
12	within 72 ene. then "na:	ldm	Elementary/Secondary (0-12)	College (1-4or 5	life	DO NOT us	e retired ARMI	)			DAT	RY FA	1DM	
א ס	Hyge H	Be Co	17. Father's Name (First, Middle, Last)				AMI		r's Name	(First, Middle,			AKII	
<u>la</u>	Aental Aental rked ric ev	To B	JACOB MOODY ROHREN	?				CHARI	LOTT	E GENEV	EVE GR	OVE		
	d 2 should th and Men 7 is marke traumatic	·	19a. Informant's Name/Relationship (T)		19b. M	ailing Address	(Street a	and Number	r or Rura	al Route Numbe	, City or Town,	State, Zip	Code)	
_	f Health item 27 other tr		KATHERINE I. ROHRI 20a. Method of Disposition	ER/SPOUSE						-	MARYLA 20c. Location -		21713	
Baltimore,	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ 6  '4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Discemetery, of			- 1		(				T 43TD
<u>=</u>	# 원립금 .		21. Signature of Fundal Server Liven	ee	FAIRVIE	22. Name an	d Addres	s of Facility	у	′2005 7606 01	KEEDYSV d Natio		-	LAND
ñ	Dapa Impo any ii		Tank 11/1	Paul .	M. Dean	BAST F	UNER	AL HO	ME 	Boonsbo				13
			23a. Part 1. Enter the disease or comp shock, or heart failure. List only o	lications that caused ne cause on each lir	the death. Do not ne.	enter the mod	e of dying	g, such as o	cardiac (	or respiratory arr	est,		Approximate Interval Bett Onset and I	ween
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a probab	le cerele	ro-va	rece	lar	au	ident			mine	te,
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200	aath certificate be executed ettending physician and for use as tha burial-transit			d										
X R O	ath cer ttendir or use	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pr	egnancy					te of delive	,	/ear
	he death the etten shed for u	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 ☐ Other (sp	ecify)				1010	((())	Day	real
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Vital Record	il or Attending Physician: The after death. Diractor: After this certificate of in by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe			(Check only or				
0	Phya rr this aral di	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	nt 2 ☐ ER/Outpa ry 28b. Time		8c. Injury Work	44		me 5 Reside			(y)	
0	r Attending Phy lar death. iractor: Aftar thii s by the funeral o	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injur	y M		k? Yes 2□N	No					
DIVISION	or Attendation of the control of the control of the choice	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ury - At home, farm, c. (Specify)	street, factory	, office			28f. Location (Si City or Town		er or Rura	al Route Num	ber,
_	To the Hospital or / within 24 hours aftar To the Funaral Dira completely filled in b		29a, Certifier 1 Certifying Phy	reinian. To the heat					11					
	P Hosp 24 ho Fund etely f	edicai	(Check only one)	sician: To the best of iner: On the basis of and manner sta	examination and/or	ath occurred investigation,	at the tim in my op	ie, date and pinion, deat	h occurr	and due to the c ed at the time, d	ause(s) and ma ate and place,	and due to	tated. the cause(s	)
	To the within To the Compl	Me	29b. Signature and title of certifier	1		290	. License	number		2	9d. Date signe	d (Month,	Day, Year)	
			Rymont	<i></i>		D	J2.	518			4/19/03	S		
11	1-5		30. Name and address of person who c			•								
	Sta	to.	Dr. Robert Gueder 31. Date filed (Month, Day, Year)		and Drive	, Keed	ysvi	lle,	MD_2	21756 /	301~43	32-22	22	
	Registi				m D.	Incet !	).							
DHN	MH 17 Rev 1/2	001		-	_									
					ORIGI	IAL								

Amend Item#1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per Fun. Dir. 4/22/08 ate of Maryland / Department of Health and Mental Hygiene
1- State BEM AACO. Health Dept. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Margaret Year Reid 10:00a M 04 12 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 803 Pasađena Avenue Severna Park
If Under 1 Year | If Under 24 Hrs. <u>Anne Arundel</u> 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F 84 Director 217-62-8164 Yrs Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits show event, the Mudical Examiner must be notified at MD Anne Arundel Severna Park Director 1 Tyes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with ō 803 Pasadena Avenue 21146 USA Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ Specify: White 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 Divorced "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Family Business 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Reid Berk Carolina Roselina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i Hunter Reid, Jr./Son 829 Pasadena Avenue, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) Apr. 16, 20a. Method of Disposition 20c. Location - City or Town, State Department of h important: if ite any injury or ot once. 1 

Burial 2 □ Cremation 3 □ Removal from State Glen Haven Cemetery Glen Burnie, MD 2005 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. ritchie Hwy, Severna Park, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or regulariture. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician nonsmall cell disease or condition resulting in death) (una cancer mos /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last attending physicien and for use as the burial-trar Due to (or as a consequence of) Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performe 2 No 2 No 1 Yes 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check on one 3 DOA Other 4 Nursing Home 5 esidence 6 Other (Specify) 1 Tes 2 No 2 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059173 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestgate Rd # 300 Annapolis, MD 2140/ 32. Registrar's Signature Remmer 31. Date filed (Month, Day, Year) 2005 Registrar

		I.	1 - For State of Maryland / State	Depa		of He	ealth a				005	14875
	Physici	20	1. Decedent's Name (First, Middle, Last)						2. Date of De.		Year	3. Time of Death
	/Medic		William Godfrey Sirman, Sr.						April	14	2005	11:22P
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, To		Location o	f Death		4c. C	ounty of Death	
	Europal		Berlin Nursing Home  5. Social Security Number 6. Sex 7. Age (In yrs. last bi	irthdav)	Ber1		If Under 2	24 Hrs.	8. Date of Birt		orceste	
	Funeral Director		213-24-0119 1™ 2□F 81	Yrs.		Days	Hours	Min.	8. Date of Bird (Month, Da Feb. 5,	y, Year) 1924		place (State or Foreign http) yland
	pu ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow									
	Aaryla shov	ь										10d. Inside City Limits 1
	28a-	rect	MD Worcester Snow  10e. Street and Number	нтт	L 10f. Zip Co	ode				10a. Citize	n of What Cour	
	h with	Funeral Director	3811 Market Street		21	863					.S.A.	rig.
	ems er mu	ner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. W	Vas Deceden Yes, specify	nt of His	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	- 14	. Race - Americ Black, White,	
j-am-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Items 23a or 28a-f show any injury or other traumatic avent, The Medical Examinal must be notified at ance.	र्व	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1	☐Yes 212		Specify:	, , , , , , , , , , , , , , , , , , , ,			inecify:	nite
₩.	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual C	done du	urina most	of worki	ng	16b. Kind	of Business/In	dustry
121	within ane. than '	Id III	Elementary/Secondary (0-12) College (1-4or 5+)	Farn	OO NOT use i	retired)			ň	Crai	n & Liv	agt agl
22	filed Hygie Sther Sant, I		12 17. Father's Name (First, Middle, Last)	ralı	пет		18. Mothe	r's Name	(First, Middle,			estock
<u>a</u>	lid be ental ked c	To Be	Elton W. Sirman						lfrey		,	
ary	should land Menia s marke		19a. Informant's Name/Relationship (Type, Print) 19th	b. Mailin	g Address (S	Street ar	nd Numbe	r or Rura	l Route Numbe	er, City or T	Town, State, Zip	Code)
ma,	and 2 ealth m 27 i		Anna G. Sirman (wife)		Mark		Stree		Snow H	i11, 1	MD 218	63
iri	Pages 1 nent of He ant: If iter		20a. Method of Disposition  20b. Place of cemeta 20b. Place of cemeta 20b. Place of cemeta 20b. Place of cemeta 20b. Place of cemeta 20b. Place of cemeta	ry, crem	atory or other	er place	)		ate	20c. Loca	tion - City or To	own, State
Sirman Wi Baltimore, Mafyland	it. Partmen rtant: njury			mori	Les				-2005	Newa	rk, Mar	y1and
Ba	permit. Departr imports any inj		21. Signature of Funeral Service Licensee	Si 13	Name and A nort F B E G	une: une:	ral H e St.	ome De	lmar, I	DE 19	9940	
of Vital Records, P.O. Box 68760,	Physician: The law requires that the death certificate be executed a per string of the certificate has been signed by the attending physicien and in page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions contributing to death but not resulting in the past 12 months? 23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown  25c. Was case referred to medical	of):	Ectopic pregi	nancy	n in Part I.		23e. Did to 1 1 1 24a. Was autopperfo 1 1 Yes (Check only o	230 bbacco use (es 2)	d. Date of delivered Month  o contribute to the No 3 Prob	Day Year  ne cause of death?  ably 4 Unknown  psy findings available impletion of cause of
Š	ysicia is cer direct	To B	examiner?	utpatient	3□ DOA	Other					Other (Specify	ν)
0	ng Ph fter th			Time of Injury	28c.	. Injury a	at	2	28d. Describe h			
Division	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, stre	M eet, factory, o		es 2 🗆 N		28f. Location (S City or Tow		Number or Rura	l Route Number,
	ospital hours a uneral [ ly filled		29a. Certifier  1 Certifying Physician: To the best of my knowledg  (Check only 2 Medical Examiner: On the basis of examination at	e, death	occurred at t	the time	e, date and	I place, a	and due to the	ause(s) ar	nd manner as st	ated.
_	Fo the H within 24 Fo the F complete	Medical	(Check only one)  2 Medical Examiner: On the basis of examination are and manner stated.  29b. Signature addition of contribute of contribute and manner stated.				number	occurre			ace, and due to	
	Le Le		M Brendul S	2	I	)2	82	6	Na A S	4,6	(5,10	5
	12		30 Name and address of person who completed cause of death (Nem 23a)  N1 (Location D. Doroductus)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	(Type, F	D Fe	w	iek	45	lend,	De	1994	74
E	Sta Registr	- 2	APR 1 9 2005	1	roule							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2005 **Physician** RONALD EUGENE SR. STOVER 8:20 AM ADO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) July 23, 1947 **Funeral**  Birthplace (State or Foreign Country) Hours 1 X M 2□F 220-42-5057 57 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental hygiene.
ant: If Item 27 is marked other than "naturel", or Itema 23a or 28a-f ehow try or other transmitter and Illied all arry or other transmitter mutalitied at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Maryland Washington Bia Pool 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10842 Shanktown Road 21711 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Chemical Company Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dewey Merle Stull Erma Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilma J. Stover Wife 10842 Shanktown Road, Big Pool, Maryland 21711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. `4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 04-22-05 Hagerstown, Maryland 21. Signature of Funeral Service License Andrew K. Coffman Funeral Home, Inc. R. hoel 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cardiomyopathy um Known disease or condition resulting in death) /Medical tibrillation Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Renal disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Asci 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 20 No Hy per lipi demia 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death
Natural
Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred s after death. 1 ☐ Yes 2 ☐ No investigation death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0058181 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PEPRAH S. Cleveland Ave Hagerstown MD 382 32. Registrar's Signature State Registrar

Amend Trems Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marcelle Shamash 13 1:20 A<sup>M</sup> April 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Manor Care Bethesda Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□ M 2□ F Yrs. 15, Director 081-56-8792 90 Nov. 1914 Baghdad, Usual Residence of Decedent with the Maryland 10a. State 10b. CPALM BEACH 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryls Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or tiems 23a or 28e-f show any injury or exter treumatic event, the Medical Examinating must be notified at once. 1√2 Yes 2 □ No Director -MD Bethesda 2860 South Ocean Blvd. #506 33480-5562 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? <del>-9104 Seven Locks</del> Road <del>20817</del> United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Yehuda Noonoo Habiba Moshe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Shamash, Husband 9104 Seven Locks Road, Bethesda, MD 20817 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 3 Removal from State 1 Burial 2 Cremation Judean Memorial Grds. 04/15/2005 01ney, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Savia Lio-nsee 11800 New Hampshire Ave Silver Spring MD 20904 23a Part Editor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Advanced Dementia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Hypertension
Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Anemia and Due to (or as a consequence of): Box 68760 Be Completed by Physician/Medical Generalized Deconditioning attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown ò Month Year Day 4☐ Pregnant at time of death 5 Other (specify) P.0. ned by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform rmed? 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 X Nursing Home 5 Residence 6 Other (Specify) dire 1 ☐ Yes 2XXXVo 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After 1X Natural 5 Pending efter death.

I Director: Af
d in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours e To the Funerel D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

32 Registrar's Signature

7710 Bradley Blvd. Bethesda, MD 20817

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kirti Vohra, M.D.

APR 18 2005

31. Date filed (Month, Day, Year)

D20274

April 14, 2005

			. For	State of Marylai				-		egible.	
١ <u>.</u>			1 - State Registrar			tificate o			Reg. No.	nns	11070
	Physici /Medi		Decedent's Name (First, Middle, Lass     Francis Clay Sipp	ole				2. Date of D	Peath Pay	<u>005</u>	3. Time of Death U
	Examir	ner	4a. Facility Name (If not institution, give  5. Social Security Number 6. Se	+ HOSPIT	()	4b. City, Town,	or Location of Dea	nd	A	County of Death	NY
	Funeral Director		-	7. Age (iii yis		Months Day		Month L April	Sirth Pay Year) 5,193	32 Penns	place (State or Foreign orty) Sylvania
	e-f show	ctor	10a. State 10b. County  MD Garrett		ity, Town or Lo rostbur					1	10d. Inside City Limits 1 ☐ Yes 2 🙀 No
	with the	Dire	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cour	ntry?
9036	be filed within 72 hours after death with the Maryland hat Hygiene. sd other than "natural", or Items 23a or 28e-f show event, the Mudical Examinar must be notified at	by Funeral Director	2652 Finzel Road  11. Marital Status  1 Never Married 2 Married 3 Widowed 4X Divorced	12. Was Decedent Ever in U Armed Forces? 1 ★ Yes 2 □ No 12, If Yes, Give Year or Dates: 12/	/10/52-	21532  Was Decedent of Yes, specify Cu	f Hispanic Origin? (Suban, Mexican, Puer o Specify:	Specify Yes or Note Rican, etc.)		4. Race - Amend Black, White, Specify:	
21215-0036	- 100	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	lent's Usual Occ kind of work don DO NOT use reti	e during most of wo	orking	16b. Kind	d of Business/In	
	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, tra M		11 17. Father's Name (First, Middle, Last)		Millw	right/Ma	aintenanc				lanufacture
lan	ould be I Mental I Marked o	To Be	Dale Edgar Sipple					E. Bow	·	umame)	
Maryland	2 should he and he ma	Г	19a. Informant's Name/Relationship (7	ype, Print)		-	et and Number or R	ural Route Num	ber, City or		
_	s 1 and 3 the sith litem 27 other tree		Dennis Sipple/Son  20a. Method of Disposition	20b.		Greenv1. sition (Name of natory or other p	lle Road,	Meyers	_	PA 1555 ation - City or To	
Baltimore,	Pages nent of ant: If It ury or o		1 □ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify	Removal from State	<ul> <li>Paul</li> </ul>	natory or other p Wilhelm	Cem.Apri	1 17,20			
Balt	permit. Pages 1 and 2 should Depirtment of Health and Mer Importent: If Item 27 le marke any Injury or other treumatic 2006.		21. Signature of Figneral Service Licens	umau	22	. Name and Add	ress of Facility N	ewman F	uneral	. Home,	Inc. 15558
760,	Physician /Medical Examiner  Ascician and per privilensity privilensit	icai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Prod Stage in Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.)	quence of):	e cardit Verotiz ca	ompopethy oranny a	stery dis	(ease	Sev Sev	Onset and Death  eval months
P.O. Box 68	The law requires that the death certificate be exite has been signed by the attending physician page 2 should be detached for use as the burial	Physician/Med	IF FEMALE: 23b. Was decedent bregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnan	ncy		23	d. Date of delive	ery Day Year
	uires that signed b d be deta	þ	Part II. Other significant conditions co	ontributing to death but not re	sulting in the ur	nderlying cause (	given in Part I.		tobacco use	_	ne cause of death?
Il Records,		Completed						24a. Wa aut per 1 🗆 Yes		24b. Were auto	psy findings available impletion of cause of 2 No
Vital	Physiclan: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	TER/Outrosi-	27.004	)ther	ath (Check only			
ion of	Attending Physic death. sector: After this by the funeral di	-	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj	4   Nursing i	10me 5 ☐ Re: 28d. Describe		Other (Specify occurred	y)
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, str ify)	eet, factory, office	е	28f. Location City or To	(Street and own, State)	Number or Rura	l Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical (	29a. Certifier (Check only one)  Certifying Phy (I Medical Exam	ysician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the restigation, in my	time, date and place opinion, death occ	e, and due to thurred at the time	e cause(s) a e, date and p	nd manner as st lace, and due to	tated. the cause(s)
)	To the within To the comp	Ň	29b. Signature and title of certifier	of mo		_	nse number	MA		signed (Month,	Day, Year)
6	AV+G		30. Name and address of person who control of the second s	completed cause of death (Ite	m 23a) (Type,	Print) zofon Dr	Ol8216 Cumber	land, N	10 21	1502	
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 0 2	32. Registrar's Sign							

KK)	CD. SI	.00	For State Registrar	State of	Maryland		artment rtificate				-	giene Reg. No.	2005	148	79
	Dhusisi		1. Decedent's Name (First, Middle	Last)							2. Date of De		. V	3. Time of E	Death
	Physici /Medio		LARRY D. STOU	T, II							APRIL			0350	$A^{M}$
i	Examir	ner	4a. Facility Name (If not institution, ROUTE # 70	give street and num	ber)		1 -	Town, or DER I	Location of	of Death			County of Dea		
	Funeral Director		5. Social Security Number  222-48-8822  Usual Residence of Decedent	6.Sex 1XXXM 2□F	7. Age (In yrs. Ia 32	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 12/23/	iy, Year)	9. Bir C DE	thplace (State or cuntry) LAWARE	Foreign
	land		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City	/ Limits
	Man)	ţō	DE SU	SSEX				LEV	WES					1 ☐ Yes	2 <b>XX</b> Vio
	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. do ther than "natural", or items 23a or 28e-f show do ther than "natural", or items 23a or 28e-f show event, it a Medical Evantinar must be notified at	Director	10e. Street and Number	-			10f. Zip					10g. Citi	zen of What C	ountry?	
	23a		30203 HOLLY L					199	958				U.S.A		
	er deg	Funeral	11. Marital Status	Armed For		13.	Was Deced	ent of Hi	spanic Ori	gin? (Sp , Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - Ame Black, Whi		
36	rs afte	by F	1 XXever Married 2 Marrie 3 Widowed 4 Divorced	ed 1 ☐ Yes 2 If Yes, Give Year or Da	)		1 ☐ Yes 2	XXNo	Specify:					HITE	
Ş	thou	edt	15. Decedent		185.	16a, Dece	dent's Usua	I Occupa	ntion			16h Kir	nd of Business		
21215-0036	hin 7.	piet	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-	4or 5+)	(Give	kind of wor DO NOT us	k done d	lurina mos	t of work	ing	100.11	10 01 20011000	rindustry	
2	ed wit	Completed	12		10.01,	ME	CAL FE	RAMEI	R				CONS	TRUCTION	[
n D	e da S	Be	17. Father's Name (First, Middle, L	ast)					18. Mothe	r's Name	(First, Middle	, Maiden	Sumame)		
Maryland		2	LARRY D. STOUT			100 200					R. ANDI		•		
a Z	12: h ar 7 ls		19a. Informant's Name/Relationsh		7D						I Route Numb			Zip Code)	
<u>e</u>	as 1 and of Health item 27 r other tr		PAMELA R. BRYA  20a. Method of Disposition	NI / MOIN	20b. Pla	ce of Dispo	sition (Nam	e of	1 -		WES, DE		28 cation - City or	Town, State	
altimore,	permit. Pages Department of I Importent: If its any injury or o		1XX urial 2 □ Cremation  '4 □ Donation 5 □ Other (Sp		tate	metery, crei	-			7 04	/20/200				
Ē	mit. 1 Dartm Sorter / injur		21. Signature of Funeral Service L								/20/200 ERAL HC			LE, DE	_
ñ	S T T C S		1 Solves	Mary.		110	$N \cap N$	DITE	TWO	PKWV	NEU	CAST	INC.	19720	
	Physician /Medical		23a Papt. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a MUL	used the death. ch line. TIPLE or as a conseque	Do not ent	or the mode	of dying	g, such as	cardiac (	or respiratory a	rrest,		Approximate Interval Betwe Onset and De	een
	Examiner	L	Sequentially list conditions, if any, leading to immediate	b											
	led sit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a conseque	ence of									
	icate be executed physician and s the burial-transit	xan	that initiated events resulting in death) Last	c Due to (o	r as a conseque	ence of):					_				
8/60,	e be e	Sail	Due to (or as a consequence of):												
		ledicai		0.											
P.O. BOX	at the death certific by the attending patached for use as to	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 Fetal on the first time of dea	death 3	Ectopic pre Other (spe					2	3d. Date of de Month	ivery Day Ye	ar
	requires that een signed b hould be deta	by Pl	Part II. Other significant condition	s contributing to dea	ath but not result	ting in the u	nderlying ca	use give	n in Part I.		23e. Did t	obacco us	se contribute to	the cause of dea	ath?
ğ	w require been sig should b	ed t									101	res 2 🛭	XNo 3□Pr	obably 4 Uni	known
I Kec	The law ate has b page 2 sl	Completed											prior to death?	itopsy findings av completion of cau	railable use of
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Manadada				1		of Death	Check on o	ne			
0	Phy this ald	- T	1 X Yes 2 □ No 27. Manner of Death			R/Outpatien		-	4 🗆 Nui					city) AT SCE	INE
	ding After fune	tlon	1 ☐ Natural 5 ☐ Pending		, Day Year)	28b. Time of Injury	40.00	C. Injury Work	at ? es 2.⊠∆	1	28d. Describe I			N COLLIS	SIDL
DIVISION	Attending r death. sctor: After by the fune	fica	3 ☐ Suicide 6 ☐ Could no	ot bo	of Injury - At hom	3.45 ne. farm. str			03 2 200					ıral Route Numbe	
=	spitel or ours after ours after ours after ours after ours after in the filled in the	Certification;	4 Homicide		of Injury - At hom g, etc. <i>(Specify)</i> OAD	, , , , , ,					City or Tov	vn, State)	T 56 1	H O	
	To the Hospitel or Attenwithin 24 hours after deal To the Funerel Director: completely filled in by the	Medical (	29a. Certifier 1 Certifying (Check only one)	Physician: To the base	est of my know	ledge, death on and/or inv	occurred a	t the time	e, date and inion, deat	d place.	and due to the	rausa(s)	and manner as	stated	•
	To th within To the	Me	29b. Signature and title of certifier				29c.	License	number				signed (Monti		
			> aual					OC.	ME			APR	IL 16,	2005	
	a		30. Name and address of person w		of death (Item 2	23а) (Туре,	Print)								
_	0		ANA RUE	310, MD			13	11 P	enn S	tree	t Bal	timor	ce, Mar	yland 21	201

State Registrar 31. Date filed (Month, Day, Year)

APR 1 9 2005

			1- State of Maryland / Department of Health and Me Certificate of Death		ene 005 14880
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Rochelle  L. Samuels	2. Date of Death Month APRII	Day Year 3. Time of Death 18, 2005 12:45AM
4	Examir		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center 4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore
6	Funeral Director		5. Social Security Number 222-32-2341 6. Sex To Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hrs. 8 Win. Oct 1 Usual Residence of Decedent	Date of Birth (Month, Day, Y	(ear) 9. Birthplace (State or Foreign Country) 1947 Delaware
	Maryland -f show	tor	10a. State 10b. County 10c. City, Town or Location DE New Castle Wilmington		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3s or 28s	Funeral Director	10e. Street and Number 1303 Delaware Ave. #1004 19806		J. Citizen of What Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-1 show any injury or other traumatic event, the Medical Evantmer must be notilied at once.	by Funera	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Novorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Na Was Decedent of Hispanic Origin? (Specific Forces)  1 Yes, specify Cuban, Mexican, Puerto Rice  1 Yes, Give 1 Yes, Sive 1 Yes 2 No Specify:	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	vithin 72 hounder.  ne.  han "natura  Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	'	bb. Kind of Business/Industry
land 2	ld be filed w ental Hygie ked other ti ic event, th	To Be Co	4 Massage Therapist  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  Clara		
, Mary	and 2 should balth and Men n 27 is marke ier traumatic	<b>j</b> -	19a. Informant's Name/Relationship (Type, Print) Aleeza Hava Oshry - Niece 3500 Labyrinth Rd.,	Route Number, C Baltim	City or Town, State, Zip Code)  ore, MD 21215
Baltimore,	Pages 1 annont of Heamant: If item		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Jewish Community Cem. 4/		oc. Location - City or Town, State Wilmington, DE
Balt	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Schoenberg Memori 519 Philadelphia	Pike,	Wilmington, DE
	Physician /Medical Examiner		23a. Part1. Enter the disease of common cations that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure of the one cause on each line.  Immediate Cause (final disease or condition resulting in death)  a. SEPSIS  Due to (or as a consequence of):  FIREMONIA	respiratory arres	t, Approximate Interval Between Onset and Death
8760,	cate be executed oblysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any leading to make a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
O. Box 6	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  CEREBROVASCULAR ACCIDENT	23e. Did toba	cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown
Vital Record	: The law requ cate has been , page 2 should	Completed		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	n; To Be	27. Manner of Seath 28a. Pate of Injury 28b. Time of 28c. Injury at 28c.		ce 6 □Other (Specify) injury occurred
Division of	I or Attending I after death. Director: After I in by the funer	Certification:	Accident investigation M 1 Yes 2 No	f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in I	edical Ce	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and and manner stated.  Check only one)	d due to the cau	se(s) and manner as stated. e and place, and due to the cause(s)
<b>)</b>	To the within 2 To the complet	Me	29b. Signature and title of certifier  D 37254	290	I. Date signed (Month, Day, Year)
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		
	Sta Regist		APR 1 9 2005	VD 2124	24

			1 - For State of Maryland / Depart Registrar Certific	tment of Health and M	, ,	
	Physici /Medic		Decedent's Name (First, Middle, Last)     Dennis Stockert			year Supplemental
	Examin	er	576 QUAKER Ridge CT.	tb. City, Town, or Location of Death  A V NO D  If Under 1 Year   If Under 24 Hrs.		4c. County of Death  A  A  Bishola (County of Death
	Funeral Director			Months Days Hours Min.	8. Date of Birth (Month, Day, Year Feb. 2, 1	9. Birthplace (State or Foreign Country) ND
	Maryland I-f show	tor	10a. State 10b. County 10c. City, Town or Locat	arnold		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	h with the 23a or 28a	Funeral Director	10e. Street and Number 576 Quaker Ridge Court	10f. Zip Code 21012	10g. C	Citizen of What Country? USA
9200	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, ite Medical Exert is at marker rediffied at ODGe.	by	1 Never Married 2 Married 1 Never Married 3 Widowed 4 Divorced 1 Never Sive Vietnam 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Ma	is Decedent of Hispanic Origin? (Spe es, specify Cuban, Mexican, Puerto i Yes 2[X]No Specify:	ocify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	ad within 72 l giene. er than "nat i, the Medice.	Completed	(Specify only highest grade completed) (Give kind	nt's Usual Occupation of of work done during most of workir of NOT use retired)	ng	V.S. Air Force
Maryland	ould be file Mental Hy arked oth	To Be (	17. Father's Name (First, Middle, Last) Alphonse P. Stockert		(First, Middle, Maide Froelich	en Sumame)
, Mar	and 2 sho saith and n 27 is ma ar trauma			Address (Street and Number or Rura. Quaker Ridge Cour		
<b>Baltimore</b> ,	Pages 1 ment of He ant: If iter ury or oth		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5 Other (Specify)	tory or other place) Apr.	15	Location - City or Town, State  ltimore, MD
Balt	permit, Depart Import any inj once.	4	21.5 m Ture Funeral Service Licensee Bar 495	ranco & Sons, P., Gov. Ritchie Hw	A. Severna y, Severna	a Park Funeral Home a Park, MD 21146
8760,	/Medical Examiner bhysician and street buriat-transit sthe buriat-transit	dlcal Examiner	25 ant 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.  Immediat Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (as as or or lying) that initiated events resulting in death) Last  C. Due to (or as a consequence of):  Due to (or as a consequence of):	A	ospitatory arrest,	Approximate Interval Between Onset and Death
.O. Box 6	ne death certif the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ect 4 ☐ Pregnant at time of death 5 ☐ Ot	ctopic pregnancy ther (specify)		23d. Date of delivery  Month Day Year
<u>α</u>	quires that the signed by all de detac	by	Part II. Dther significant conditions contributing to death but not resulting in the under	orlying cause given in Part I.		o use contribute to the cause of death? 2 to 3 ☐ Probably 4 ☐ Unknown
al Records,		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
of Vital	hysician his certif Il director	To Be		26. Place of Death  3 DOA Other: 4 Nursing Hom		6 ☐Other (Specify)
Division of	Attending Physician: The I st death. ector: After this certificate he ector: After this certificate he by the funeral director, page	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 VSuicide 6 Could not be	Work?	28d. Describe how injude the control of the control	ury occurred 9 Se 14
D	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		4 Homicide determined building, etc. (Specify)	, factory, office 2	P.B.f. Location (Street a City or Town, Sta Arrold	1 (44)
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death or control on the basis of examination and/or invest and manner stated.	atigation, in my opinion, death occurre	ed at the time, date an	nd place, and due to the cause(s)
	To To		29b. Signature and title of certifier  Chillen Pan, mo	29c. License number  D 0 0 0 6 0 5		ate signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	D000605	erica	21035
	Sta Registr	_	APR 1 5 2005	rock		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 2005 1020 Nathalie Hoffman /Medical Truitt 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 59/15/110 Wicinico If Under 1 Year | If Under 24 H/s. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🛱 F Days Yrs. 216-18-2371 Director 12/22/1915 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 625 Truitt St. 21801 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ŏ 1 ☐ Yes 2X No Specify: other traumatic event, the Madical Example Completed by white Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry parmit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then "I eny injury or other traumatic event, ITA MAY 2002. Elementary/Secondary (0-12) College (1-4or 5+) Baker Bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanley Helen Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3751 Village Trail, Snow Hill, MD 21863 of Disposition (Name of Date 26. Location - City or Town, State Kathy T. Sheldon/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 → Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Springhill Memory 4/21/2005 Hebron, MD 22. Name and Address of Facility Signature of Euperal Service Licenses Holloway Funeral Home Professional Association and 23a. Part1. Enter the disease, or complications that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (\* as roonsequence of): **Physician** 7 Days /Medical **Examiner** Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 DUnknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA Medical Certification; To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funerel I 29a, Certifier 1🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

Delmarvaltea + lic

Suite 605

Sylvens MD

Server

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

D. Bounds

APR 1 9 2005

freeliges

Date filed (Month, Day, Year)

			1 - State Registrar	State of		nd / Depa		of He	ealth and	Mental Hy		Jible.	14883
	Physici	an	Decedent's Name (First, Middle					-	-	2. Date of D Month	eath Day	Year	3. Time of Death
	/Medi		Douglas	Tinsley						Apri1	14, 200	05	9:31 a M
	Examir	ier	4a. Facility Name (If not institution		er)				ocation of De	ath		nty of Death	
	Eurovol		Holy Cross Hos  5. Social Security Number		Age (In vrs.	last birthday)	If Under 1		Spring	rs. R Date of R		gomer	<u>-</u>
	Funeral Director		224-34-3953	1⊠M 2□F	73	Yrs.		Days	Hours Mi	n. (Month, D	ay, Year) 3, 1931		place (State or Foreign intry) Sinia
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	Maryl	ō		George		istric		hte					1 ☑ Yes 2 ☐ No
	28a	rec	10e. Street and Number	deorge		150110	10f. Zip 0				10g. Citizen o	of What Cou	intry?
	h with	by Funeral Director	1881 Tanow Plac	ce					20747		-	d Sta	,
	deal	ner	11. Marital Status	12. Was Decede Armed Force			Was Decede	nt of His	panic Origin?	(Specify Yes or Nerto Rican, etc.)	o- 14. R	ace - Ameri	ican Indian,
36	or It	y Fu	1 Never Married 2 Marr		□No 1	777	1 ☐ Yes 2xi		Specify:	erto moan, etc.)	Spec	lack, White,	, etc. Lack
Ö	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Modeal Examil et rivel be notified at	d b	3 ¼Widowed 4 □ Divorced		is: 1 2								
5	in 72	olete	15. Decedent (Specify only highes	it grade completed)		16a. Dece (Give	dent's Usual kind of work DO NOT use	done du retired)	ion iring most of w	rorking	16b. Kind of	Business/ir	ndustry
212	filed with Hygiene. Ither than	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		ing As				Medic	al	
פַ		BeC	17. Father's Name (First, Middle,	Last)		1				ame (First, Middle			
<u>a</u>	should be ind Mental marked c	ToE	James Thomas T:	insley					Dorot	hy Mae D	avis		
Maryland 21215-0036			19a. Informant's Name/Relations			19b. Mailir	ng Address (	Street ar	nd Number or I	Rural Route Numi	per, City or Tow	m, State, Zij	p Code)
a)	s 1 and 2 of Health Item 27 I		James T. Tinsle	ey/Son	loo! r					ontgomer			36105
20	M Ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation			Place of Dispo cemetery, cres				Date	20c. Location	-	
Baltimore,	it. Pertiment		'4 □ Donation 5 □ Other (S		Met	_			, ,	ril 20,			andria, Va.
Ba	permit. Peges 1 Depertment of H Important: If Ite eny injury or ot once.		21. Signature of Funeral Service	- Consee	W	Ä	1exand 1315	Address ler ock	of Facility S. Pope Wood Dr	Funeral Silver	Homes Spring	P·Ma.	20904
П			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau only one cause on eac	sed the deat h line.	th. Do not ent	er the mode	of dying	such as cardi	ac or respiratory	arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition			ract I							Onset and Death
	/Medical Examiner		resulting in death)		as a consec	quence of):							
		<u>_</u>	Sequentially list conditions,	b. Sept	SÍS as a conseq	wansa oft.							
	nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			al Fai	lure					1	
	al-tra	xar	that initiated events resulting in death) Last	C	as a conseq								
68760,	death certificate be executed e attending physicien and od for use as the burial-transit	cai		d. Hype	erkale	mia							
89	ntifica ng ph as th	Medi	IF FEMALE:										
Вох	leath certific attending p	an/l	23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth			Ectopic pred	nancy				Date of delive	,
	e dea the at hed fo	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnan 9☐Unknow	t at time of d		Other (spec				, N	Month	Day Year
P.0	that the de led by the a detached f	Ph/	Part II. Other significant condition	IRS contributing to deat	h hut not ron	ulting in the	-		in Donal	an Did		-1-7	
Records,	es ign be	d by	Chronic atr			alling in the u	nderlying cau	ise giver	in Parti.				he cause of death?
Ö	w requir been s should	etec			461011								Jabiy 42 Olikilowii
Rec	The lav	ompleted	Hypertensio	n						24a. Was		b. Were auto prior to co death?	opsy findings available empletion of cause of
Vital		e Co	25. Was case referred to medical							1 Yes	2 <b>%</b> No	1 Yes	2 🗆 No
Ē	Phyeician: this certific ral director,	o Be	examiner?	Hospital:	otiont 2	ER/Outpatien	1 7 DO 1	Other		eath (Check only			
0	g Ph) er this		27. Manner of Death	28a. Date of I	njury	28b. Time of		. Injury a	ıt	Home 5 ☐ Res 28d. Describe	how injury occi		(y)
Ö	Attending I r death. actor: After by the funer	atio	1 XNatural 5 ☐ Pendin 2 ☐ Accident investig	9	Day Year)	Injury	М	Work?	s 2 No				
Division	or Atten efter deat Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 289. Place of	Injury - At he	ome, farm, str	eet, factory,	office		28f. Location	Street and Num wn, State)	nber or Rure	al Route Number,
	Ital or A Irs efter ral Dire led in by	Cer											
	the Hospital or Al in 24 hours effer the Funeral Direct impletely filled in by	edicai	29a. Certifier 1 → Certifyin (Check only 2 → Medical I	g Physician: To the be Examiner: On the basi and manner	est of my kno s of examina stated.	owledge, death tion and/or inv	occurred at restigation, in	the time my opii	, date and plac nion, death occ	ce, and due to the curred at the time	cause(s) and r date and place	nanner as s e, and due to	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	10:		- 0	29c. I	icense	number		29d. Date sign	ed (Month,	Day, Year)
	1		Sauma	a rho	m	al	D	0058	965		Apri1	14, 20	005
2	15 1/2		30. Name and address of person	who completed cause of	of death (Item	n 2βa) (Type,	Print)					,	
	-		Saima Khawaja	, MD. 11119	Rock	ville	Pike;	Rock	ville,	Md. 208	52		5%
	Sta Registr	-	APR 1 9 20		strar's Signa	Shee	K						

		Decedent's Name (First, Middle, L.	State of Maryla 1/18/05,BMW,McCo		rtificate of	Deam	2. Date of D Month	Reg. No. eath Day	3. Time	of Death
Physic /Medi		Marion Eliza					April	12, 200		)3 A
Exami		4a. Facility Name (If not institution, gi			4b. City, Town, or	Location of Dea	ith	4c. County	of Death	
		4606 Merivale Ro			Chevy			Mont	gomery	
Funeral Director			Sex 1 ☐ M 2 K F 7. Age (In ye	rs. last birthday)	If Under 1 Year   Months   Days	If Under 24 Hrs Hours Min	8. Date of B (Month, D	rth[0-20-19] ay, Year) +1901	De Birthplace (State Country) Rhode Is1	e or Forei
No TH		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside	City Limit
Department of Health and Mental Hygiene. Important: It item 27 is marked other than "natural", or items 23a or 28a-f show amounts: if item 27 is marked other than "natural", or items at the notified at once.	to	Md. Montgom	nery C	hevy Ch	ase				1 ⊠ Y	es 2 🗆 N
or 28	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?	
23a	ai	4606 Merivale R	load		2081	5		U.S	.A.	
tems er m	by Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (: in, Mexican, Pue	Specify Yes or N rto Rican, etc.)	o- 14. Rac	e - American Indian,	,
0 1	ν. F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give	-	1 ☐ Yes 2 🛣 No			Specify	<i>r</i>	
tural E E	ed b	15. Decedent's 8	Year or Dates:	16a Daca	dent's Usual Occup	ntion			white	
And And	Completed	(Specify only highest gi	rade completed)	(Give	kind of work done of DO NOT use retired	during most of wo	orking	160. Kind of Bu	usiness/Industry	
r tha	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		Home Mak			Own Ho	me	
othe vent,	Be C	17. Father's Name (First, Middle, Las	it)				me (First, Middle	, Maiden Sumam		
denta rked tic ev	To E	Thomas Kaveny				Mary 1	E. Early			
and he ma		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street a	and Number or A	iural Route Numb	er, City or Town,	State, Zip Code)	
n 27		Mary Ellen Whitc	9				#302 Bet	hesda,Ma	aryland208	316
# iter		20a. Method of Disposition 1 X Buriai 2 ☐ Cremation 3 [	Bernoval from State	<ul> <li>Place of Disposition</li> <li>cemetery, crei</li> </ul>	sition (Name of matory or other place	θ)	Date	20c. Location -	City or Town, State	
ant:		'4 □Donation 5 □Other (Spec	ify) Ga		Heaven Ce		1116,05	Silver S	Spring, Md.	
Depart Import any in		21. Signature of Funeral Service Lice	96///		2. Name and Address					
		23a. Part1. Enter the disease, or cor	MH		222 Wisc.				0007	
nysician Medical kaminer		disease or condition resulting in death)	A Hypertensi Due to (or as a cons		iovascuia	r Diseas	se		25 v	ears
en and rial-translt	Ä	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons	equence of):			=			
l by the attending physicien and stached for use as the burial-transit	icai Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	b. Due to (or as a cons  c. Due to (or as a cons  d. 23c. If yes, outcome of predictive birth 2 Fe 4 Pregnant at time of 9 Unknown	equence of): gnancy stal death 3 [ f death 5 [	JEctopic pregnancy			23d. Dat Mor	e of delivery	Year
signed by the attending phy: d be detached for use as the	by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	b. Due to (or as a cons  c. Due to (or as a cons  d. 23c. If yes, outcome of predictive birth 2 Fe 4 Pregnant at time of 9 Unknown	equence of): gnancy stal death 3 [ f death 5 [	Other (specify)	en in Part J.	23e. Did	tobacco use contr	e of delivery	Year
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ate has been signed by the attending phy. page 2 should be detached for use as the	Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?	b. Due to (or as a cons  c. Due to (or as a cons  d. 23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown  contributing to death but not re	equence of):  gnancy stal death 3 [ f death 5 [ esulting in the u	Other (specify)	26. Place of De	23e. Did 1 24a. Was auto perfe 1 Yes ath Check on	More tobacco use control Yes 2 No an 24b. V promed? 2 No 1	e of delivery inth Day  ribute to the cause of  3 Probably 4  Vere autopsy finding rior to completion of leath?  Yes 2 No	Year f death? Unknow
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ler death. irector: Atler this certificate has been signed by the atlending phy. n by the funeral director, page 2 should be detached for use as the	To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	b. Due to (or as a cons  c. Due to (or as a cons  d. 23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time or 9 Unknown  contributing to death but not r  Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	equence of):  equence of):  gnancy stal death 3 [ f death 5 [ esulting in the u  ER/Outpatier 28b. Time of Injury	other (specify)  Inderlying cause give  It 3 DOA Other  28c. Injury Work  M 1 N	26. Place of De	23e. Did  1  24a. Was auto perfe 1 Yes ath Check on Home 5 Resi 28d. Describe	Mon  tobacco use contr  Yes 2 No  an 24b. V psy prmed? 2 No 1 one  dence 6 □Othe how injury occurre  Street and Number	e of delivery  nth Day  ribute to the cause of  3 Probably 4 [  Were autopsy finding  prior to completion of  leath? 2 No  er (Specify)	Year  f death?  Unknowi
ler death. irector: Atler this certificate has been signed by the atlending phy. n by the funeral director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1   X Yes 2   No    27. Manner of Death 1   X Natural   5   Pending investigation   2   Accident   3   Suicide   4   Homicide   1   Certifying P	b. Due to (or as a cons  c. Due to (or as a cons  d. 23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time or 9 Unknown  contributing to death but not re  Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	equence of):  equence of):  gnancy stal death 3 [ f death 5 [ esulting in the u  ER/Outpatier 28b. Time of Injury  home, farm, str cify)	other (specify)  Inderlying cause give  at 3 DOA  28c. Injury Work  M 1 DO  Deet, factory, office	26. Place of De  4 Nursing I at ?  4s 2 No	23e. Did  1	More tobacco use control Yes 2 ₹ No 24b. V psy ormed? 2 ₹ No 1 1 0 0 ne dence 6 □ Other how injury occurrol Street and Number win, State)	e of delivery inth Day  ibute to the cause of a Probably 4 [  Were autopsy finding prior to completion of leath?  Yes 2 No  er (Specify) ed	Year  f death?  Unknowl s available cause of
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eath. or: Alter this certificate has been signed by the attending phy. the funeral director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical Ex	IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No 9   Unknown     No   Was a present   No   No   No   No   No   No   No   N	b. Due to (or as a cons  c. Due to (or as a cons  d. 23c. If yes, outcome of preg 1	equence of):  equence of):  gnancy stal death 3 [ f death 5 [ esulting in the u  ER/Outpatier 28b. Time of Injury  home, farm, str cify)	other (specify)  Inderlying cause give  28c. Injury Work  M 1 1	26. Place of De  26. Place of De  at ??  des 2 \( \text{No} \)  e, date and place inion, death occur number	23e. Did  1	Monotobacco use control Yes 2 No  an 24b. V psy primed? 2 No 1 one dence 6 □Othe how injury occurre  Street and Number wm, State)  cause(s) and maidate and place, a	e of delivery inth Day  inbute to the cause of a Probably 4 [  Were autopsy finding prior to completion of death?  Yes 2 No  er (Specify) ed  er or Rural Route Number or Rural Route Number as stated.  Indidue to the cause [ (Month, Day, Year)	Year  If death?  Unknown  Is available cause of

Physician /Medical Examiner 4a. F  Funeral Director 5. So to the marked other than "natural" or items 23s or 28s-1 enow 10s. 10s. 10s. 10s. 10s. 10s. 10s. 10s.	Alle  10b. County  Maryland  10b. County  Alle  10b. County  Alle  10b. County  Alle  13 From  Marital Status  1 Never Married 2 Married  15 Decedent's Edu (Specify only highest grade)  16 Specify only highest grade  17 Secondary (0-12)  10  Father's Name (First, Middle, Last)  Courts  A. Informant's Name/Relationship (T)  Mabel J. Bevan/	Mabel Justreet and number, le Nursing Hox 7. As and 20 F	ge (In yrs. last bi 90 10c. City, Tow Ever in U.S.	yrs. If Me 13. Was If Ye 1 □	Decedent of Hiss, specify Cuba	Lonaconii	eath naconing  Hrs. 8. Date of Bi (Month, Di Februar)	Day pril 18, 2005 4c. County 4d. County 10, Year) y 22, 1915	9. Birth Cou	egany  place (State or Fore ntry)  Maryland  10d. Inside City Limi  122 Yes 2 1 ntry?  A  can Indian, etc.
Medical Examiner  4a. F  Funeral Director  Los Completed by Funeral Director  To Be Completed by Funeral Director  10e.  11. V  13.  120.  120.  120.  130.  130.  14. F  15. So of 28a-1 ellow word that then "natural" or items 23a of 28a-1 ellow word that then "natural" or items 23a of 28a-1 ellow word that the mail of the mail o	Social Security Number 218-30-0795   1	street and number, le Nursing Hox  x	ge (In yrs. last bi 90 10c. City, Tow	yrs. If Me 13. Was If Ye 1 □	On Days  On Decedent of Hiss, specify Cuba  Yes 2 No	Lonaconi  Lonaconi  21539	eath laconing  Hrs. 8. Date of Bir (Month, Dir Februar)  ng	pril 18, 2005  4c. County  tth ay, Year) y 22, 1915  10g. Citizen of V	of Death Allo	egany  place (State or Fore intry)  Maryland  10d. Inside City Limit 12 Yes 2 1 Noty?  A  can Indian, etc.
To the aith and Mental Hygiene.  10e.  10e.  10e.  10e.  10e.  10e.  10e.  10e.  10e.  10e.  10e.  10e.  10e.  11e.  10e.  10e.  11e.  10e.  11e.  10e.  11e.  10e.  11e.  10e.  11e.  10e.  11e.  10e.  11e	Social Security Number 218-30-0795   1	gany  ont Street  12. Was Decedent Armed Forces' 1   Yes, Give Year or Dates: Jucation (e. completed)  College (1-4or ()	ge (In yrs. last bi 90 10c. City, Tow Ever in U.S.	yrs. If Mo	On Days  On Decedent of Hiss, specify Cuba  Yes 2 No	Lonaconi  Lonaconi  21539	Hrs. B. Date of Bir (Month, Da Februar	10g. Citizen of V	9. Birthi Cou What Cou US	egany  place (State or Fore ntry)  Maryland  10d. Inside City Limi  122 Yes 2 1 ntry?  A  can Indian, etc.
of Health and Mental Hygiene.  Illem 27 is marked other then "natural", or items 23a or 28a-f show to other traumatic event, the Medical Examiner must be notified at 10er.  To Be Completed by Funeral Director 11. P. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	218-30-0795  Jal Residence of Decedent  I. State Maryland  D. Street and Number  13 From Marital Status  1 Never Married  15 Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)  10  Father's Name (First, Middle, Last)  Courting  Alle  15 Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)  10  Father's Name (First, Middle, Last)  Courting  A. Informant's Name/Relationship (7)  Mabel J. Bevan/	gany  ont Street  12. Was Decedent Armed Forces; 1  Yes, Give Year or Dates: ucation (e completed)  College (1-4or 0)	90  10c. City, Tow  Ever in U.S. No	vn or Locatio	on Days  On Zip Code  Decedent of Hiss, specify Cuba  Yes 2 No	Lonaconi  21539  (spanic Origin', Mexican, Pi	ng	10g. Citizen of V	What Cou US	Maryland  10d. Inside City Limi  1 ⊠Yes 2 □ N  ntry?  A  can Indian, etc.
of Health and Manial Hygiene.  I lem 27 is marked other then "natural", or items 23a or 28a-f ehow r other traumatic event, fre Medical Exercise must be netified at 11. y 11. E.  To Be Completed by Funeral Director 13. a	Alle Maryland  Street and Number  13 From Marital Status    Never Married 2   Married     Never Married 2   Married     Specify only highest grade	ont Street  12. Was Decedent Armed Forces' 1  Yes 2  Was I'yes, Give Year or Dates: acation (e completed)  College (1-4or 0)	Ever in U.S. No	13. Was If Ye 1 □	Decedent of Hiss, specify Cuba	21539 Ispanic Origina n, Mexican, Pi		o- 14. Rac Blac	What Cou US	1 ⊠Yes 2 ☐ f ntry? A can Indian, etc.
117. E To Be CC To Be	Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)  10  Father's Name (First, Middle, Last)  Courts  a. Informant's Name/Relationship (T)  Mabel J. Bevan/	ont Street  12. Was Decedent Armed Forces' 1  Yes 2  Was I'yes, Give Year or Dates: acation (e completed)  College (1-4or 0)	No 16a	13. Was If Ye	Decedent of Hiss, specify Cuba	21539 Ispanic Origina n, Mexican, Pi		o- 14. Rac Blac	What Cou US	1 ⊠Yes 2 □  ntry?  A  can Indian, etc.
117. E To Be CC To Be	Marital Status  1 Never Married 2 Married  3 Moderated 4 Divorced  15. Decedent's Edu (Specify only highest gradelementary/Secondary (0-12) 10  Father's Name (First, Middle, Last)  Courts  a. Informant's Name/Relationship (T)  Mabel J. Bevan/	12. Was Decedent Armed Forces' 1   Yes 2 2 1 1 1 Yes, Give Year or Dates: Jucation College (1-4or ()	No 16a	13. Was If Ye	Decedent of Hiss, specify Cuba Yes 2 No	ispanic Originî n, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)	o- 14. Rac Blac	US.	A can Indian,
117. E To Be CC To Be	1 Never Married 2 Married 3 Midowed 4 Divorced  15. Decadent's Edu (Specify only highest grad Elementary/Secondary (0-12) 10  Father's Name (First, Middle, Last)  Courts a. Informant's Name/Relationship (T)  Mabel J. Bevan/	Armed Forces; 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:  Ication Is completed)  College (1-4or 0	No 16a	1 🗆	Yes 2 No		? (Specify Yes or No uerto Rican, etc.)			etc.
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117. E To Be CC To Be	(Specify only highest grad Elementary/Secondary (0-12) 10  Father's Name (First, Middle, Last) Courts a. Informant's Name/Relationship (7) Mabel J. Bevan/	College (1-4or		(Give kind life. DO I	's Usual Occupa					White
117. E To Be CC To Be	Father's Name (First, Middle, Last)  Courts a. Informant's Name/Relationship (T)  Mabel J. Bevan/	0	<u> </u>			furing most of )		16b. Kind of Bu		
norm of Health and Manfall in: If Hem 27 is marked of rry or other traumatic even rry or other traumatic even 7 or 96 To Be	Courtr a. Informant's Name/Relationship (T) Mabel J. Bevan/	ney Henry Be			Cor	fectionar	<u> </u>		Bak	ery
19a. 20a. 20a. 20a. 20a. 20a. 20a. 20a. 20	Mabel J. Bevan/		eckman			18. Mothers	Name (First, Middle Stella	Lee Rose C	ower	
nent of Hear	Mathad of Disserting		191	b. Mailing A			Rural Route Numb			Code)
nut: #	i. Method of Disposition		20b. Place o	of Dispositio		1	Date	20c. Location ·		own, State
	1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	'		demorial Pa		April 21, 2005	Cumb	erland,	, Maryland
Department Important: 1 any injury o	Signature of Funeral Service Licens				ame and Addres	-	ral Home 8 Eas	st Main St., L	บกลังก	ing, Md. 215
kaminer  Sequence cause cause that	quentially list conditions,  adding to minibulate see. Enter Underlying use (Disease or injury t initiated events ulting in death) Last	b. Use to (or as	s a consequence	of):  MINO.	tasta se		Can cor			3 ments
detached for use as the detach	FEMALE:  0. Was decedent pregnant in the past 12 months?  1 □ Yes 2 → No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□ Pregnant a 9□ Unknown	2 Fetal death		opic pregnancy her (specify)			23d. Dat Mor	e of delive	ery Day Year
bauti bauti Parti	t II. Other significant conditions con	ntributing to death t	out not resulting $His$	in the under	rlying cause give	en in Part I.				he cause of death
cate has been signed by the attending page 2 should be detached for use a:  Completed by Physician/Me	adeno carcino	m4 of	breast					psy prmed? d		opsy findings availampletion of cause
25. V	Was case referred to medical examiner?	Hospital:			Otho		Death (Check only o			
After this of funeral dir.	Manner of Death    Natural   5   Pending     Accident   Investigation	28a. Date of Inju (Month, Da		Time of Injury	28c. Injury Work	Nursin	g Home 5 Resident Res	dence 6 □Othe how injury occurr		<u>(v)</u>
S S S S S S S S S S S S S S S S S S S	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury · At home, fa tc. (Specify)	arm, street,			28f. Location (. City or To	Street and Numbi wn, State)	er or Rura	Il Route Number,
n 24 hours he Funera pletely fille edical C	a. Certifier 12 Certifying Phy. (Check only one)	sician: To the best ner: On the basis of and manner st	of examination ar	e, death occ nd/or investi	curred at the tim igation, in my op	e, date and pla pinion, death o	ace, and due to the courred at the time,	cause(s) and ma date and place, a	nner as s	tated. the cause(s)
M 29b.	o. Signature and title of certifier				29c. License			29d. Date signed		
	/home/	Epile	inmo		000	214	88	April	18.	2005
10 30.1	Name and address of person who co	ompleted cause of of Declin in 1999	death (Item 23a)	(Type, Print	(a) Ave	45	longon	in the	121	539

Physic		1 - For Amend Item Ragistrar  1. Decedent's Name (First, Middle, La Mary Ellen TURNEI	ist)					2. Date of Month		ıy Year	3. Time of D
/Medi Exami		4a. Facility Name (If not institution, given 441 North Potoma 441 Potomae		Apt.9		y, Town, or	Location of		40	c. County of Deal ashing to	
Funeral Director		5. Social Security Number 6. S 220-64-7012 Usual Residence of Decedent	Sex 7. Ag 1 □ M 2 🖾 F	je (In yrs. last bin 49		ler 1 Year	If Under 24	Min. (Month,	Birth Day, Year, 1 1,19	9. Birt	hplace (State or I bunity) 'yland
a or 28e-f show Lbe nutified at	ctor	10a. State 10b. County Maryland Washir	ngton	10c. City, Town	or Location	n					10d. Inside City
23a or 28 ist be no	ai Director	10e. Street and Number 441 North Potomac	St. Apt.	9	10f. 2	Zip Code 2174	40			tizen of What Co	ountry?
ral, or items:	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		If Yes, sp	edent of Hi ecify Cuba 212 No	spanic Origin n, Mexican, I Specify:	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, White Specify: W	
ne. han "natur e Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ade completed)  College (1-4or		Decedent's Us (Give kind of v life. DO NOT	vork done d use retired	lurina most o	f working	16b. K	(ind of Business/	Industry
ental Hygiene. ked othar than ic evant, the M	To Be Co	12 17. Father's Name (First, Middle, Last Isaac F. Barthe			<u>labore</u>			Name (First, Mid	dle, Maider	ood n Sumame)	
aith and Mental F 27 Is marked of r traumatic evan	F	19a. Informant's Name/Relationship ( Raymond W. Barthe	Type, Print)	4.1			nd Number	or Rural Route Nu	mber, City		
ent of Health nt: ff Itam 27 I ry or other tra	150	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specif	Removal from State	20b. Place of cemeter	Disposition (Ny, crematory or	ame of other place	9)	Date	20c. L	ocation - City or gerstown	Town, State
Department important: if eny injury or goce.		21. Signature of Funeral Service Licer	•		22. Name	and Addres	s of Facility		CH FU	NERAL HO	ME
ician and burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	c	a consequence o							
by the attending phys ached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ▼Unknown	d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic 5 □ Other (s				-	23d. Date of delin	very Day Yea
been signed beshould be det	by	Part II. Other significant conditions of	contributing to death b	ut not resulting in	the underlying	cause give	n in Part I.		d tobacco u ☐ Yes 2	use contribute to	3.6
ate has page 2	Completed							24a. W au pe 1 X Yes	topsy rformed?	death?	topsy findings ava ompletion of cause 2 No
n. After this funeral di	atlon; To Be	25. Was case referred to medical examiner?  1X Yes 2 No  27. Manner of Death  1X Natural 5 Pending investigation	Hospital: 1  Inpatie 28a. Date of Inju (Month, Da			28c. Injury Work	r: 4 🗌 Nursi	Death Check on ng Home 5 Re 28d. Describ	sidence	6 ☑Other (Spec. y occurred	iiy)At scer
rs after de al Diracto led in by th	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, far c. <i>(Specify)</i>	m, street, facto	ry, office		28f. Location City or	(Street an Town, State	d Number or Rui )	ra i Route Numbe
	Medical	one)	ysician: To the best niner: On the basis of and manner sta	examination and	death occurred Vor investigatio	d at the time n, in my op	e, date and p inion, death	place, and due to the control occurred at the time	ne cause(s) e, date and	and manner as place, and due	stated. to the cause(s)
iin 24 hou <b>tha Fune</b> ipletely fi		29b. Signature and title of certifier			29	c. License	number		29d. Dat	e signed (Month	, Day, Year)
within 24 hours after death  To tha Funeral Diractor: completely filled in by the	×	· hing his,	mis		Į.	OCI	ME		Apri.	1 26,200	)5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Tully State of Maryland / Department of Health and Mental Hygiene 1 5

1- State Unpend Item 23a,27,28a-f per me C843.5-37.55 tas

Registrar 05 - 2531AKG 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician William Michael Tully 11, April 2005 6:14 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1730 Clarkson Street Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 01/01/1933 **Funeral**  Birthplace (State or Foreign Country) Months Days 1**⊠**M 2□ F Hours 215-28-2233 72 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Director 1 X Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tams 23a or 1730 Clarkson Street 21230 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) 5 Supervisor Water Department permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itan 27 is marked ofth any injury or other traumatic avent, page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Michael Tully Mary Steurnagle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Tully / Son 1874 Hawk Court, Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 04/14/05 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G. J. Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) r nysician Contact gunshot wound of head /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Box 68760, Completed by Physician/Medical the attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ pknown 24a. Was an has 1 Yes of Vital 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: P 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ②Other (Specify) at scene 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Natural  $\mathbf{a}^{\mathsf{M}}$ 2 Accident subject shot self Diractor: 4-11-05 6:00 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1730 Clarkson St. determined 4 | Homicide Hospital or residence within 24 hours a To the Funeral L Baltimore, Maryland 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State

MAY 0 2 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MA

111 Penn Street B

OCME

Baltimore, Maryland 21201

April 11, 2005

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	ate of Marylan		rtment of H		_	giene Reg. No.	11115	14888
2	Physici /Medic Examir	al	Decedent's Name (First, Middle, Last)     Locality Name (If not institution, give street)	and number)		Uma 4b. City, Town, o	or Location of Deat	2. Date of De Month	Day	Year ZOOS	3. Time of Death 2:55p M
*XI	Funeral Director		5. Social Security Number  5. Residence of Decedent	NS HOSF 7. Age (In yrs. I 68	ast birthday) Yrs.	Bultin H Under 1 Year Months Days	MORQ ( if Under 24 Hrs Hours Min.	Pti	th y, Year)		**
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23c or 28a-f show any njury or pihar traumatic avant, The Modical Examination and phose.	To Be Completed by Funeral Director	1 Never Married 2 Married 1 3 Widowed 4 Divorced Y  15. Decedent's Education (Specify only highest grade com	as Decedent Ever in U.smed Forces?  Yes 2 No Yes, Give ear or Dates:  pleted)  pilege (1-4or 5+)	16a. Decedor (Give koller) 19b. Mailing 15616 ace of Disposimetery, crem yland 22.	20707  Vas Decedent of I Yes, specify Cub.  Yes 2 No  ent's Usual Occup ind of work done  Caster  Address (Street Plaid ition (Name of atory or other plac  Natior  Name and Addre	dispanic Origin? (San, Mexican, Pueric Specify:  Specify:  18. Mother's Nar Halima and Number or Ru  Dr., La  20)  11. Mother's Nar Halima and Number or Ru  Dr., La  20)  12. Mother's Nar Halima and Number or Ru  Dr., La  20)  13. Mother's Nar Halima and Number or Ru  Dr., La  20)  14/14  Ss of Facility Ur	pecify Yes or No o Rican, etc.)  rking  me (First, Middle, atu Um  ral Route Number aurel, Date  1/2005  niversa	Nige 16b. Kind Rad Maiden S aru or, City or 1 Md. 20c. Loca Laur 1 Mo	en of What Cour  ria  Race - Americ Black, White, Specify: bl  d of Business/In- lio Sta  umame)  Town, State, Zip 20707 ation - City or To el, Md  rtuary	10d. Inside City Limits 1  Yes 2  No  ntry?  can Indian, etc.  ack  dustry  tion  Code)
8760,	cate be executed / Medical Examiner the private ransit the burial-transit	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Is that caused the death ise on each line.  A CUT- VS  Due to (or as a consequence to (or as a consequ	ence of):	r the mode of dyin	hess sardiac	or respiratory ar	rest,		DC 20011 Approximate Interval Between Onset and Death SChours
.O. Box 68	ne death certifi the attending hed for use as	Physician/Medi	in the past 12 months?	yes, outcome of pregnar  Live birth 2	death 3 □E	Ectopic pregnancy Other (specify)	,		236	d. Date of delive Month	ry Day Year
<u>α</u>	w requires that the been signed by should be detact	þ	Part II. Other significant conditions contribut human immunodel	•		derlying cause giv			bacco use		e cause of death?
Vital Records,		e Completed	coagulopothy 25. Was case referred to medical	· deficion c	7 54	ndrom		24a. Was a autop perfor 1 Tyes	med? 2 X No	prior to con death?	osy findings available inpletion of cause of
Division of Vi	iing Phys	atlon: To B	examiner?  1  Yes 2 No Hospita  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Ainpatient 2 LE	ER/Outpatient 28b. Time of Injury	28c, Injun Worl	er: 4 □ Nursing H	ome 5 Resid	ence 6		)
DİXİ	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	Il Certification:	4   Homicide	e. Place of Injury - At hor building, etc. (Specify)			1	28f. Location (S City or Tow	n, State)		
	To the Hos within 24 h To the Fun completely	Medical	(Check only 2 Medical Examiner: O	n the basis of examination manner stated.	on and/or inve	estigation, in my of	Dinion, death occui	red at the time, o	late and pl	ace, and due to	the cause(s)
•	3		30. Name and address of person who complete Mark Yoder 1830		23a) (Type, P	rint) 5th C	-9575-	elknow		1 12, D 2120	
	Sta Registr	te ar	31. Date filed (Month, Day, Year) APR 18 2005	ad cause of death (Item:  E. Manum  32 Registrar's Signatu	for Apr	de	1 13		·		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Viers Trace 1:30 A-M 2005 04 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Cheverly Prince Prince George If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 07-08-1940 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 XF Hours 64 247-64-2354 Yrs. Director Sout Carolina Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Madical Examiner must be notified at Stafford Stafford VA. 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Waterview USA 22554 102 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If itsm 27 is marked other then "naturel", or ite Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2X No þ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Internal Kevenus Service BRANCH MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Donaldson Joseph L. Mildred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health a important: If itsm 27 is any injury or other training. Myers - Sister Rd. Collinsville, MS. 39325 12246 Thea ATCICIA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State SPOTSYLVANIA, VA. 4-7-05 Aurel Hill Memorial Rock ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Lavrel 0502870026 10127 Plank Rd Dutsylvania 1/2 2253 Funeral Home 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sheet, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) DAYS /Medical Examiner A-V malformation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the attending physiclen and thed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed2 2 No director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t atural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours afte To the Funeral Dir completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5 30. Name and address of person who se of death (Item 23a) (Type, Print) K. Michael Figaro Hospital Cheverly, Md 20785 3001 9 2005 Registrar's Signature State Registrar

			Please 1'  1 - For State Registrar	ype or Print in State of Maryla	nd / Depa	artme		ealth and	Mental Hyg		2005	14890
	hysicia /Medic	an	1. Decedent's Name (First, Middle, Last) Evelyn Elizabeth	VIANDS					2. Date of Deat Month April 1	Day	005 Year	3. Time of Death  1:45 a. M
The court of the court	Examin	_	4a. Facility Name (If not institution, give s  Avalon Manor	treet and number)		1		Location of Deat	h		ounty of Deat ashingt	
	uneral rector		5. Social Security Number 6. Sex 217-18-7142	M 2⊠F 7. Age (In yr	s. last birthday) Yrs.		gersto erlYear Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 2		9 Rint	hplace (State or Foreign untry) aryland
Maryland	a-f show		Usual Residence of Decedent  10a. State 10b. County  Maryland Washing		City, Town or Lo		rstow	n				10d. Inside City Limits 1X Yes 2 No
with the	a or 28	Direc	10e. Street and Number 138 Winter Street			10f. Z	ip Code	21740	1	0g. Citize	on of What Co USA	untry?
<b>5-0036</b> 72 hours atter death with the Maryland	item 27 is marked other than *natural; or itams 23a or 28a-f show other treumatic event, the Medical Examiner must be nutified at	by Funeral Director		2. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Was Deci If Yes, sp			pecify Yes or No- o Rican, etc.)		I. Race - Ame Black, White	
215-0036 ithin 72 hours aft	natura adical B	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	dent's Us	ual Occupation	tion uring most of wo	rking	16b. Kind	d of Business/	Industry
2121 ad within giene.	the M	omo	Elementary/Secondary (0-12)	College (1-4or 5+)			naker			her	own ho	ome
e, Maryland 2121 1 and 2 should be filed within Health and Mental Hygiene.	arked othe	To Be C	17. Father's Name (First, Middle, Last) Edward Dunahugh					Ada Gr	ne <i>(First, Middl</i> e, <i>M</i> iffith			
Mar d 2 sho th and	7 is m treum		19a. Informant's Name/Relationship (Type Terry W. Burger -		1				ıral Route Number gerstown			
			20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Re	20b.	Place of Dispo cemetery, cre	osition (Na matory or	ame of other place	)	Date	20c. Loca	ation - City or	Town, State
Baltimore, permil. Pages 1 al Department of Hea	Importent: If item any injury or othe once.		'4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		dar Law				23/05 MINNICH F			n, Maryland E
<b>m</b> & 8	E 8 8		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	Musen				The second second	l., Hager		n, Md.	21740 Approximate
/Me	sician edical miner parial-transit	Examiner	snock, or near failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a const	equence of):	lise	ax_		lay di		ic	Interval Between Onset and Death
Box 687	attending phys for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3[	⊒Ectopic   □ Other (s	pregnancy specify)			23	d. Date of deli Month	ivery Day Year
ords, P.O	been signed by the should be detached	þ	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	ınderlying	cause give	n in Part I.		acco us		the cause of death?
- Re	ate has	Completed	`						24a. Was a autops perform	y ned?	24b. Were au prior to death?	topsy findings available completion of cause of
of Vita Physician:	is certificate director, paç	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3 🗆 🗆	Cthe		ath (Check only on	-/		
<b>□</b> 2	fter th	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	-		28c. Injury Work		dome 5 Reside			CHY)
Division of or Attending s after death.	To the Funeral Director: A completely filled in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st	reet, facto	ry, office		28f. Location (St City or Town	reet and n, State)	Number or Ru	ıral Route Number,
a Hospit 24 hours	e Funeri etely fille	edical (	29a. Certifier Check only one) Sartifying Phys	ician: To the best of my ker: On the basis of exami	nowledge, deat nation and/or in	th occurre evestigation	d at the time in, in my opi	e, date and place inion, death occu	a, and due to the caurred at the time, d	ause(s) a ate and p	ind manner as place, and due	stated. to the cause(s)
To the	<b>То th</b> compl	Me	29b. Signature and title of certifier				9c. License		2	9d. Date	signed (Month	h, Day, Year)
SH-	F		30. Name and address of person who co	mpleted cause of death (It	rem 23a) (Type,		1 1	Haapy	town	M	D 71	742
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	nerth	1	J	1 70011		- dies !	

			1 – For State Registrar	State of Ma	aryland		ent of He			ene	5	4891
	Physici /Medic Examir	al	Decedent's Name (First, Middle, La     Aa. Facility Name (If not institution, given the content of the con	e street and number)	ste	4b. (	City, Town, or Lo	ocation of Death	2. Date of Death	Day 4c. Count		3. Time of Death
	Funeral Director		Usual Residence of Decedent	TYN OFF	30	Yrs. Mon		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/15/	Year) 1924		ace (State or Foreign try) Land
	h the Marylan r 28e-f show inotified at	irector	Maryland Wicom  10e. Street and Number	Lco		Town or Location  Lisbury  106	Zip Code		10	g. Citizen of		0d. Inside City Limits 1 ☐ Yes 2 ☒ No try?
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Evantest must be notified at	by Funeral Director	213 Potomac Ave.  11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ N	o Arm	Y If Yes,	_	anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - America ck, White, e	etc.
Maryland 21215-0036	d within 72 hour giene. ir than "natural the Medical Ex	Completed b	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12) 10	Year or Dates: ducation ade completed) College (1-4or 5		16a. Decedent's l	work done dur T use retired)	on ing most of worki	ng 1	6b. Kind of B	usiness/Ind	ite <sub>lustry</sub>
ryland 2	should be filed and Mental Hyg markad othe amarkad othe amarkad othe	To Be C	17. Father's Name (First, Middle, Last Carl David Webste 19a. Informant's Name/Relationship (	er Sr.		19b. Mailing Add		Beatrio	(First, Middle, M Ce Tyler al Route Number,	aiden Suman	me)	Code)
Baltimore, Ma			Beverly Wilkins/6  20a. Method of Disposition  1 \( \mathbb{X} \) Burial 2 \( \mathbb{C} \) Cremation 3	aughter	ce		shire D	r., Sal:	isbury, I	MD 2180 Oc. Location	01 City or Tov	wп, State
Baltin	permit. Page Department of Importent: If any Injury or once.		* 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Licer W.P. Mallon	msee	Par FSP	k 22. Nam HOII 501	and Address of Oway Fu Snow Hi	of Facility neral Ho 11 Rd.,	ome Profe Salisbur	Y, MD	·	and a time
,0,	Physician /Medical Examiner parisisten and provided provided transit	Examiner	23a. Part1. Enter the disease, or com some content failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Makes	a conseque	Do not enter the ince of):	node of dying, s	known	Prin	st,		Approximate interval Between Onset and Death
.O. Box 68760,	death certificate e attending phy: d for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome  1 Live birth  4 Pregnant at 9 Unknown	2 Fetal c	leath 3 □Ectopi	pregnancy (specify)			23d. Dai	te of deliver	y Day Year
Δ.	w requires that the been signed by the should be detache	by	Part II. Other significant conditions o	ontributing to death bu	ut not result	ing in the underlyir	g cause given i	n Part I.			nbute to the	e cause of death?
Vital Records,	The taw ete has b page 2 st	e Completed	25. Was case referred to medical						24a. Was an autopsy perform	No !	Were autoportion to compleath?	sy findings available pletion of cause of
of	ding Phys	ToB	examiner? 1  Yes 2 No  27 Manner of Death Natural 5 Pending	Hospital: Inpatie	v 2	R/Outpatient 3 28b. Time of Injury	DOA Other: 28c. Injury at Work?	4 Nursing Hon	(Check only one) ne 5 Residen 8d. Describe how	ce 6 □Oth		
Division	e Hospital or Attanding 24 hours after death. 9 Funeral Director: After etely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	. (Specify)	e, farm, street, fac	tory, office	2	28f. Location (Stre City or Town,	State)		
	To the Hospital of within 24 hours at To the Funeral D completely filled it	Medical	29a. Certifier (Check only one) Certifying Ph (2 Medical Example) Medical Example 29b. Signature and title of certifier	ysician: To the best of niner: On the basis of and manner sta	examinatio	n and/or investigat	ed at the time, of ion, in my opinion 29c. License nu	on, death occurre	ed at the time, date	se(s) and ma e and place, a d. Date signed	and due to t	the cause(s)
-	6 mP WA		30. Name and address of person who	completed cause of de	eath (Item 2	(3a) (Type, Print)	DO	3627 Bx 1733	18 C.	4-11	4-05 MA	21802
ì	s Sta	160	31. Date filed (Month, Day, Year) APR 1	2005 <sup>32. Registra</sup>	r's Signatu		wer	~	, see	7	7 013	# · ! U ·

			1- State of Maryland / Department of Health and Certificate of Death	d Mental Hy	/giene	5 14892
			1. Decedent's Name (First, Middle, Last)	2. Date of D	eath _	3. Time of Death
	Physic /Medi		Lafayette Stanley Wilson	April	Day 16	oas 1552 M
	Exami		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Di	eath	4c. County of	Death
			feninsula Regional Medicul Center 34/1564	M		mico
	Funeral Director		212-40-8742 64 Yrs.	8. Date of Bi lin. (Month, D 3/2/19	orth ay, Year) 941	Birthplace (State or Foreign Country)  Maryland
	land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
	with the Maryland a or 28a-f show	ţō	Maryland Wicomico Salisbury			1 X Yes 2 No
	h the	Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizen of Wh	at Country?
	23a c	alD	121 Van Buren St. 21804		USA	
1	or death tems 23	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or Nuerto Rican, etc.)	o- 14. Race -	American Indian, White, etc.
R	36 rs after i', or ite	by F	1  Never Married 2 Married 1	,	Specify:	white
200	-00 P hou	edit			16b. Kind of Busin	
2.	vithin 72 ene.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working	Tab. Kind of busin	less/industry
7	2121 ad within giene. er than "	l e	12 – Assembly Line Worker		Crown, Co	rk & Seal
1	laryfand 212 2 should be filed with and Mental Hygiene, is marked other than aumatic event, the	Be (	01 - D		, Maiden Surname)	
- 3,	Mend	ို		nanda Rig		
3	iore, Maryand 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryla tt of Health and Mental Hygiene. If item 27 is marked other than "natural" or items 23s or 28s 1 show or other traumatic event, the Medical Examinat must be notified at		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or			ate, Zip Code)
Th	e, land Healt em 2		Charlene M. Foxwell/daughter 13880 Backbone Rd.  20a. Method of Disposition (Name of	Eden, MD		Children Children
V	Baltimore, Ma Bermit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tran		1 ☐ Burial 2 【Cremation 3 ☐ Removal from State cemetery, crematory or other place)		20c. Location · Ci	
1	Iltir nit. P artme ortan injur.	_	'4 □ Donation       5 □ Other (Specify)       SalisburyCrematory       4/2         21 Signature of Funaral Service Licensee       22. Name and Address of Facility	21/2004	Salisbur	, MD
	B Ped Girls		Holloway Funeral	Home Pro	ofessiona	Association
	100000		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line	liac or respiratory a	oury, MD	Approximate
	Physician		Immediate Cause (Final		192	Interval Between Onset and Death
	/Medical		resulting in death)  a  Due_t (or as a consequence of):	maj		
1	Examiner	L	Sequentially list conditions. b. Creleronascular acc	colex	1	A
d	ed sit	Examiner	Sequentially list conditions: if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  c.			
74	xecut and	xan	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
8	68760, filtrate be executed physician and ts the burial-transit	alE				
0	68 tifficate ng phy as the	ledical	d.			
7	Box sath cert	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the part 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of	f delivery
3	G deat	sicia	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year
7	P.O.	Phys	9 U OTIKNOWA			
0	res th	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1		te to the cause of death?
	Orc requi	eted		- 10	Yes 2□No 3[	Probably 4 Unknown
	Division of Vital Records, to Attending Physician: The law requires taller death.  Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed		24a. Was	DSV DIIO	e autopsy findings available to completion of cause of
	al F n: Th ficate rr, pag			1 ☐ Yes	rmed? dea 2☐No 1☐	th? Yes 2□ No
	Vit elcial	o Be	Hospital:	eath (Check only o		
	Of Phy or this	n: To	- Indistrict Electrodipation 3 DOA 4 Nulsing		dence 6 Other (	Specify)
	ion rading ath. r: Afte e fun	atio	27. Manner of Death    Z8a. Date of Injury   28b. Time of   28c. Injury at		many observed	
	VIS r Atte er de recto by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (. City or To	Street and Number of	r Rural Route Number,
	Distal or rai Di				,	
	Division of Vital Records, P.O. Box ( To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edicai	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plated and plate and p	curred at the time,	date and place, and	or as stated. due to the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier 29c. License number		29d. Date signed (A	fonth, Day, Year)
	( n		10 HOOS74	0	4/16/	15
	8 MM	١,	30. Name a ress of person who comp se of death (Item 23a) (Type, Print)			
			Simona Eng 100 E. Carroll St. Salisbury, N.	10 2/80	2/	
	Sta Registi		29b. Signature and title of certifier  29c. License number  400574  30. Name a ress of person who comp see of death (Item 23a) (Type, Print)  5 mon Lng 100 E. Carroll St. Salisbury No. 31. Date filed (Month, Day, Year)  APR 1 9 2005			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 13, APRIL 2005 12:40p M JULIUS WILLIAM WILSON /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 4720 Leroy Gorham Dr. Capitol Heights Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Director 86 1918 Goodwater, Ala. June 26, 172-22-0549 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits itam 27 is marked other than "natural", or Itams 23s or 28s-f show other traumatic event, the Madical Examiner must be notified at 1 X Yes 2 □ No Directo Maryland Prince Georges Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4720 Leroy Gorham Dr. 20743 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filled within 72 hours after on and Mental Hygiene. Is marked other than "natural", or Ital 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 ₩idowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 3 Special Police / FBI Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Daivd W. Wilson Dolly Corprew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 is n any injury or other traun 2006. 36 Galveston Street S.W. Washington, D.C. Evelyn P. Martin / Daughter 20032 20b. Place of Disposition (Name of cemetery, crematory or other). 20a. Method of Disposition 20c. Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial 4/20/2005 Landover, Md. \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Alexander S. Pope Funeral Homes, P.A.
5538 Mariboro Pike/Forestville, Md. 21. Signatur of Funeral Service License Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, solicitor Cause (Final 20747 23a. Part I. Enter the disease, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician URINARY RETENTION /Medical Due to (or as a consequence of): **Examiner** BENIGN PROSTATIC HYPERTROPHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Pop in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 **X**No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 1x Yes 2 No 2 4 Nursing Home 5 Residence 6 □Other (Specify) this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Diractor: After 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide To the Hospital within 24 hours a To the Funeral I 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MO MD D0055061 APRIL 14, 2005 address of person who completed cause of death (Item 23a) (Type, Print) AUBRIE J. NAGY, M.D., 50 IRVING STREET N.W., WASHINGTON, DC 20422/688 31. Date filed (Month, Day, Year, 2. Registrar's Signature State APR 1 9 2005 Registrar

			1 - For State Registrar Amend# 2.Per						d Mental Hy	giene Reg. No. ()	05	14894
*	Physici /Medi		Decedent's Name (First, Middle, Las  Teresa	Ann	Wade				2. Oate of De Month Ar	or $oldsymbol{ iny}$ Day $oldsymbol{1}$	5, Year 0	3. Time of Death 10:12 A <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give Shady Grove Hospi	street and number)	wate	4b. City,	Town, or L	ocation of C		4c. Co	ntgome	
ľ	Funeral Director		5. Social Security Number 6. Se 577-08-0453		(In yrs. last birthda Yrs.	y) If Under Months		If Under 24	Hrs. 8. Date of Bir (Month, Date July 2)	th ly, Year)	9. Birth Cou	place (State or Foreign intry)
	Maryland -f show	tor	Usual Residence of Decedent	erv	10c. City, Town or							10d. Inside City Limits 1X Yes 2 □ No
	with the a or 28a	Director	10e. Street and Number  20518 Staffords			10f. Zip	Code 0874	·			of What Cou	intry?
-0036	be filed within 72 hours after death with the Maryland nat Hygiene. Ind chier than "natural", or itams 23a or 28a-1 show of other than "natural", or itams 23a be collised at event. If a Medical Exactifier must be notified at	ed by Funeral	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		3. Was Deced	lent of Hisp city Cuban, 2 <b>X</b> No	Mexican, P	? (Specify Yes or No uerto Rican, etc.)	Sp	Race - Amen Black, White ecify:	Black
1215	within 72 ene. than "nat	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+	(Gi life	ve kind of wor b. DO NOT us	rk done du se retired)	ning most of				
Maryland 21215-0036	2 should be filed within n and Mental Hygiene. n and Mantal Hygiene ' is marked other than ' raumatic ovent, It & Ma	To Be Co	17. Father's Name (First, Middle, Last)  Floyd T. Wade Sr.	3 yrs	Logi	ISTIC M			Specalist Name (First, Middle, elia Mil	Maiden Sur	ernment	<u> </u>
Mary	nd 2 shorth and A 12 stooms 12 stooms 12 stooms 15 stoom		19a. Informant's Name/Relationship (7)  Vandelia Wade/Mot						Rural Route Number			o Code) vland 20874
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked any injury or other traumatic ©		20a. Method of Disposition  1	Removal from State	20b. Place of Discometery, co	position (Namrematory or of Le Creu 22. Name and	ne of ther place) nator; d Address	y 4/	Date	20c. Locati Rivero kins l	ion - City or T dale , Ma Funera	own, State aryland L Home
8760,	Cate be executed /Medical Examiner   /Medical Examiner   // // // // // // // // // // // // /	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Intro  Due to (or as a  b. Sepsi  Due to (or as a  c. Respi	Cerebral consequence of):	Hemorr		such as car	ulac or respiratory al	rest,		Approximate Interval Between Onset and Death
.O. Box 6	requires that the death certifics een signed by the attending ph hould be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal death	3 □Ectopic pre i □ Other (spe				23d.	Date of deliver	ery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but	not resulting in the	underlying ca	iuse given	in Part I.		obacco use d		ne cause of death?
Vital Record	The law ate has b page 2 s	e Completed	25. Was case referred to medical						1 Yes	rmed? 2 No	prior to co death?	psy findings available mpletion of cause of
Division of Vi	Phys this al dir	To B	examiner?  1 Yes 2XNo  27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	Hospital: 1X Inpatient 28a. Date of Injury (Month, Day 1	28b. Time		Other: Bc. Injury at Work?	4 Nursin	Death Check only on g Home 5 Residence Residence Page 1	lence 6 🗆		y)
DIX	Dir	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	(Specify)				City or Tow	m, State)		l Route Number,
	To tha Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	xamination and/or	ath occurred a investigation,	it the time, in my opin	date and plate on the determinant of the determinan	ace, and due to the occurred at the time, o	ause(s) and date and plac	manner as st	ated. the cause(s)
)	To the vithin 2 To the complet	M	29b, Signature and title of certifier		2 nin		License n	umber		29d. Date sig	ned (Month,	
2	(15)		30. Name and address of person who co			e, Print)						
	Sta Registra		31. Date filed (Month, Day, Year)  APR 1 9 2005	300 Registrar	s Signature		• 1F S	LTO KO	CKVIIIE,	TOI y Ta	.14 200	

			For State Registrar	State of Mai	ryland / Depa <i>Cei</i>	artment <i>rtificate</i>	of H	ealth a Death	and M		ene	5	1489	5
40	Physici /Medio	al	Decedent's Name (First, Middle, Last)     KELLY HENRY WOOD     4a. Facility Name (If not institution, give see			4b City T	Own or	Location	of Dogsth	2. Date of Death Month APRIL	Day 11,	Year 2005	3. Time of De 8:00P	
	Examir		HOLY CROSS HOSPIT  5. Social Security Number 6. Sex	4b. City, Town, or Location of Death  SILVER SPRING  If Under 1 Year   If Under 24 Hrs.   8				G MONTGOMER				nreian		
	Funeral Director			M 2□F	(In yrs. last birthday) 61 Yrs.	Months	Days	Hours	Min.	JULY 17,	<sup>Year)</sup> 1943	WASH	elace (State or Fontry) LINGTON,	DC
	be filed within 72 hours after death with the Maryland that Hyglene. ad other than "neturel", or Items 23e or 28e-f show event, I're Medical Exartirat must be natilised at	Director	10a. State     10b. County     10c. City, Town or Location     10d. Inside City Limits       MARYLAND     PRINCE GEORGES     FORESTVILLE     XX yes 2 □ No       10e. Street and Number     10f. Zip Code     10g. Citizen of What Country?											
Maryland 21215-0036		l by Funeral Director	8113 STEVE DRIVE  11. Marital Status  1 Never Married XX Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes XXXNo If Yes, Give Year or Dates:	,	Was Decede if Yes, specif	nt of His fy Cubar	0747 spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bla	CED ST ce - Americ ck, White, fy: BLAC	an Indian, etc.	
		Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12TH	cation e <i>completed)</i> College (1-4or 5+	(Give	dent's Usual kind of work DO NOT use	done d retired)	(uring most		ng		RAL GO	dustry OVERNMEN	ΙΤ
	should be fill nd Mental H marked oth imatic even	To Be	17. Father's Name (First, Middle, Last)  ISAAC WOOD  19a Informant's Name/Relationship (Tv	rne Print)	19h Mailir	na Address /	Street a	UN	KNOW				Code)	
altimore, Ma	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		19a. Informant's Name/Relationship (Type, Print)  LORETTA WOOD / WIFE  20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State											
Baltin			4 □ Donation 5 □ Other (Specify) 21. Signature of Fundral Service License	rshll			Addres L S	s of Facility FUNE	, RAL	0/2005 HOME OF SUITLA		AND, IN	IC.	
8760,	w requires that the death certificate be executed  been signed by the attending physician and should be detached for use as the burial-transit	edicai Examiner	23a. Part Etter the disease, or complishook of heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	SEPSIS  Due to (or as a Due to (or as a c.	consequence of):  consequence of):  consequence of):	er the mode	of dying	g, such as	cardiac o	r respiratory arre	st,		Approximate Interval Betwee Onset and Dea	n th
.O. Box 6		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)								23d. Date of delivery Month Day Year			
rds, P		by	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes ※※ No 3 ☐ Probably 4 ☐ Unknown				
of Vital Records,	The law ate has b page 2 sl	Completed							_	24a. Was an autopsy perform	ed?	prior to cor death?	psy findings avai npletion of cause 2 No	ilable e of
on of Vita	Attending Physicien: Thradeath. sotor: After this certificate by the funeral director, pag	tion: To Be	examiner?  1   Yes XX No											
Division	tel or Attend is after death el Director: / ed in by the f	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certiflier (Check only one)  XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
0	To the within 2 To the comple	W	29b. Signature and fittle of/certifier  29c. License number  D61890  30. Name and address of person who completed cau of ath (ite 3a) (Type, Print)						29	29d. Date signed (Month, Day, Year)  APRIL 15, 2005				
K	Sta Registr		ANURADHA DAHIYA, 31 Date filed (Month, Day, Year)  APR 1 9 2005	M.D.		1500 F	ORE	ST GL	EN R	D. SILVE	R SPRI	ING, M	4D 2091C	)

1 - For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19,12005 Year **Physician** APRILGLORIA YOUNG FAYE 4:15 D. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DOCTORS HOSPITAL PRINCE GEORGE LANHAM| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | OCT • 20 1 949 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F VIRGINIA Yrs 55 226-72-3618 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show traumatic event, the Madical Examiner must be notified at 1 XYes 2 ☐ No MARYLAND PRINCE GEORGE BOWIE MARYLAND Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 11811 FROST DRIVE 20720 U.S.A.or Items 23a death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 🗆 Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) TELACOMMUNION  $A \cdot T \cdot T$ 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ges 1 and 2 should be fill tof Health and Mental H Be PETER YOUNG, SR. THELMA LUMPKIN YOUNG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SON) WILLIAM O. YOUNG, III 11811 FROST DRIVE BOWIE MARYLAND 20720 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 XBurial 2 Cremation 3 Removal from State Ξ injury or permit. Page Department Important: If any injury o LORETTO VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) FIRST BAPTIST CHURCH 4/24/05 22. Name and Address of Facility 21. Signature of Funeral Service Licensee BERRY O. WADDY P.O.BOX 305 LANCASTER VA. 22503 23a. Part1. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BREAST CANCER- METASTATIC Physician /Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of it july) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit that the death certificate be executed the attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical as the IF FEMALE: esn esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No ģ 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. ğ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ğ 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Cer iffication: After 1 Alatural Division To the Hospital or Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation r death. 2 T Accident ector: filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a To the Funeral C 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4-19-05 D 23743 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 7525

2005 32. Registrar's Signature

O.WELTZW

MARTIN

31. Date filed (Month.

GREENWAY CENTER DRIVE GREENBELT MARYLAND 20770

State of Maryland / Department of Health and Mental Hygiene 2005Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician 9:40 PM April 21, 2005 Frances R. Antetomaso /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Parkville Oakcrest Village 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 ☐ M 2 🂢 F 85 Dec 9, Yrs. 1919 417-16-9311 Alabama Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other then "naturel", or Items 23s or 28s-1 show other traumatic event, the Medical Exact art must be notified at MD Baltimore Parkville 1 ☐ Yes 2 ☑ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8820 Walther Blvd 21234 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 X Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked othe any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Roberts Rose Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gloria Edel/daughter 37 Tudor Court Timonium, MD 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Euneral Sice Licensee Ronald S. Wade, Director non Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseque e of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) anding physician and use as the burial-transit Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 month 3 Ectopic pregnancy Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2 10 Division of Vital 25. Was case referred to medical examiner? 26. Place of Death Check only one Be Hospital: 1 Inpatient Other: 4 In rising Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours are: \_\_\_\_ To the Funerel Director: A \_\_\_\_\_ To the funerel Director Director: A \_\_\_\_\_ To the funerel Director Dire death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) wilther 32. Registrar's Signature Registrar

Antelomado

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CHARLES ADAMS, JR. 20e5 mau /Medical 4a. Facility Name (If not institution, give street and numb 4b. City Town, or Location of Death 4c. County of Death Examiner Anne Burnie orth USpita Glen runde If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1, M 2□ F Yrs. Director 219-16-1218 July 26, 1926 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location or 28e-f show other treumetic event, the Mudical Examiner must be notified at 1 ∑Yes 2 □ No Maryland Anne Arundel Directo Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #35 Old Solamons Island Road 21401 U.S.A. 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: Black 3√ Widowed 4 Divorced "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed within and Mental Hygiene. 6 Years Broadcaster Radio Station 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Adams, Sr. ۵ Ruby L. Queen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is any injury or other tre once. Charles W. Adams, III 6761 Villa Juares Circle Sacramento California 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 5 ☐ Other (Specify) 5-5-2005 Hill Crest Cemetery Arrapolis, Maryland 22. Name and Address of Facility Rollins Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4339 Hunt Place, N.E. Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any Itaan to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ en Sion 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No certificate has 20 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 1 Inpatient 2 2 ER/Outpatient 3 DOA

Division of Vital Records, P.O. Box 68760

this After 1 To the Hospitel or Attending within 24 hours after death. To the Funerel Director: A

> State Registrar

Certification:

nper of

3 🗌 Suicide

29a, Certifier

4 | Homicide

Natural

Accident

29b. Signature and title of certifier

28c. Injury at Work?

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

augen my eted cause of death (Item 23a) (Type, Print) orth Arundel haiyemo mD

31. Date filed (Month, Day, Year)

5 Pending

investigation

6 Could not be determined

and manner stated

2005

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		For Amend Item 10	State of Maryland C per fn 6843	I /Department of He 5-3-05 tas Certificate of D	ealth and Mental H Beath	ygiene	14899
*		Decedent's Name (First, Middle, Last)			2. Date of D		3. Time of Death
Physici /Medi		ANTOINET	TE M.	ARTHUR	1111-1	4c. County of Dee	5 7100 M
Examir	ier	4a. Facility Name (If not institution, give s	COR N.H.	4b. City, Town, or 1	MORE	12/A	etn
Funeral		5. Social Security Number 6. Sex		st birthday) If Under 1 Year   Months   Days	If Under 24 Hrs. 8. Date of B Hours Min. Month, C	irth 9. Bir	rthplace (State or Foreign
Director	4	2/4-03-26/6 10	83	Yrs.	MARCH	F 20, 1920	MD.
yland		10a. State 10b. County	10c. City,	Town or Location			10d. Inside City Limits
Ba-fal	ctor	MD. N/A	Dig !	TIMORE	Baltimore	T	1 Pes 2 No
with the a or 2	Dire	10e. Street and Number	20)	10f. Zip Code	21/	10g. Citizen of What C	· L ·
death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	i. 13. Was Decedent of His	panic Origin? (Specify Yes or N , Mexican, Puerto Rican, etc.)	No- 14. Race - Am Black, Whi	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene are the more and the standard of the standard is a fame and the standard at the incities are traumatic avent, the Medical Exeminations as the incities at an once.		1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ₺ No	Specify:	Specify:	HITE
21215-0036 sd within 72 hours af gjene. er than *natural; or	Completed by	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decedeni's Usual Occupati (Give kind of work done du	ion ring most of working	16b. Kind of Business	s/Industry
within sene.	idu	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	LV	FACTA	DLY
riled 2 I Hygie other	Be Co	17. Father's Name (First, Middle, Last)	1.75	126	8. Mother's Name (First, Midd	le, Maiden Sumame)	
should be nd Mental marked o	To B	ANDREW C	WIKLINS	Kı	PELAGI	A KOSZ	YK
Maryland of 2 should be file lith and Mental Hy 27 is marked oth		19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailing Address (Street and	Number or Rural Route Num	1 44	Zip Code) 2 / 2 3 U
re, l		20a. Method of Disposition	COL	ace of Disposition (Name of metery, crematory or other place)	Date	20c. Location - City or	r Town, State
Pages nent of I		1  Burial 2  Cremation 3  R  '4  Donation 5  Other (Specify)	emoval from State	· STANISLAU	S	BHLTO.	MD.
Baltimore, permit. Pages 1 a Department of He Important: If Item any injury or othe once.		21. Signature of the real Service Ligense	* Sparle	22. Name and Address	of Facility  F.H. 232	PHUDSOI LID M	N 57" D 21224
		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death.	Do not enter the mode of dying,	such as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	ASW	10			Onset and Death
/Medical Examiner			Due to (or as a conseque	ence off: RNILLAT	D-A .		VA
√n =	ner	Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying	Due to (or as a conseque		, 0, 2		/ /
Box 68760, eath certificate be executed attending physician and for use as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):			
68760, ficate be ex physician is the buria	dicai E						1
68 rtificati		IF FEMALE:					
Geath certif	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnan 1□Live birth 2 □ Fetal of 4□Pregnant at time of dea	death 3 Ectopic pregnancy		23d. Date of de Month	Day Year
. 5 . 5	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	atil 3 - Other (specify)			
	by P	Part II. Other significant conditions con	tributing to death but not result	ting in the underlying cause given	_	tobacco use contribute t	
Records, the law requires to has been signed age 2 should be	eted	D line	A TA			UPAR	Probably 4 Unknown
I Rec	Completed	01772	An pritu		per	opsy prior to formed? death?	completion of cause of
	a	25. Was case referred to medical			1 ☐ Yes 26. Place of Death (Check only		s 2□No
of Vita Physician: r this certific ral director.	To B	1 Tes 2 (1940	ospital: 1   Inpatient 2   E		4 Nursing Home 5 He		ecify)
On C ding P h. After t	tion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury a Work?  M 1 □ Ye		e how injury occurred	
ViSion Attention death	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office	28f. Location	(Street and Number or Rown, State)	Rural Route Number,
Hospital or 24 hours affe Funeral Directed filled in		29a. Certifier 1 ☐ Certifying Phys	injury. To the heat of my know	lodge dooth convered at the time	data and place, and due to the	o agues/s) and manner a	e etated
To the Hospital within 24 hours a To the Funeral C completely filled	edicai			riedge, death occurred at the time on and/or investigation, in my opin			
To th within To th comp	Me	29b. Signature and title of certifier		29c. License	number	29d. Date signed (Mon	
		1		U 2 9		4-26-0	
6		30. Name and address of person who co	mpleted cause of death (Item)	ZJa) (Type, Print)	er to	212 4	
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	лье			
Regist	rar	mai u 3	2005 PROME	He Angella			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Patricia Ruth Allen 28 2005 April 7:15a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4516 Allen Road Randallstown Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2√□ F Yrs. Director 220-34-7309 Jan 19 Md Usual Residence of Decedent death with the Maryland 10a. State 10c. City Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at Md Baltimore Randallstown Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4516 Allen Road 21133 USA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White <u>ک</u> 3 Widowed 4 Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other treumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Co. Schools crossing guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Frederick Schemm Mildred Palmer ္ဝ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Allen (spouse) 4516 Allen Rd., Randallstown, Md 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State Wards Chapel Cemetery 5-2-05 Marriottsville, Md ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee ▶ Vaige Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that thused the death shock, or heart failure. List only one cause in a colling. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Finysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): Box 68760 attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Inknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? 2 10 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Besidence 6 Other (Specify) 2 1 Yes 2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) I Director: After to d in by the funera 27. Manner - eath 28b. Time of 28d. Describe how injury occurred Certification: 1 I atural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \text{Homicide} \) within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check onli License number 29b. Signature title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person 0 leted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

028	000		1 - State Amend Item 1&U	State of Maryland / Dep Inpend Item 23a, pt.	artment of Health and III 27, 28a-f per rtificate of Death5-1	Mental Hygie me G843 8-05 tas Reg	005  490
	Physici		1. Decedent's Name (First, Middle, Last)	John F. Augusty	•	2. Date of Death Month April 26	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give st Franklin Square Hos	reet and number)	4b. City, Town, or Location of Dea Rosedale	th	4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 6. Sex 219-22-4468 1 Sex Usual Residence of Decedent	7. Age (In yrs. last birthday, M 2□ F 77 Yrs.	If Under 1 Year   If Under 24 Hr.   Months   Days   Hours   Min		9. Birthplace (State or Foreign Country) MARTYLand
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. I do other than "natural", or Items 23a or 28a-f show avant. I're Medical Errer if were ust be recilied at	eted by Funeral Director	10a. State MD Baltimo:  10e. Street and Number 11209 Beach Roc  11. Marital Status    Never Married 2   Married   Widowed 4   Divorced    Specify only highest grade	a d  2. Was Decedent Ever in U.S. Armed Forces? 1 ZeVes 2 Do If Yes, Give Year or Dates: ation 16a. Dece	e MArsh  10f. Zip Code  21162  Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Puel  1□Yes 22 No Specify:  Ident's Usual Occupation  Is kind of work done during most of wo	Specify Yes or Norto Rican, etc.)	10d. Inside City Limits 1 □ Yes ※ No  Citizen of What Country?  JSA  14. Race - American Indian, Black, White, etc.  Specify: White  D. Kind of Business/Industry
Maryland 2121	be filed ital Hygi id other avant, I	To Be Completed	Elementary/Secondary (0-12)  12th  17. Father's Name (First, Middle, Last)  Frank Augustyni	College (1-4or 5+) Stee	el Worker	me (First, Middle, Mai	Beth Steel
	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic Once.		19a. Informant's Name/Relationship (Type Joseph Augustyni 20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □ Re  '4 □ Donation 5 □ Other (Specify)  21. Signature of Funerar Service Licens	Lak /son 86 W moval from State 20b. Place of Dispo cemetery, created HollyHi	ng Address (Street and Number or R VaterViewWay Ed Street (Name of matory or other place) L11Cemetery 4/3 2. Name and Address of Facility 300 Mace Ave	dgewood M Date 200 30/05 E	D 21040  Location - City or Town, State  Baltimore MD  IneralHomeofEssex
ı	Physician /Medical Examiner		resulting in abutily	ations that caused the death. To not enticause on each line.  Iemothorax due to to Due to (or as a consequence of):  Due to (or as a consequence of):	ter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
68760,	The law requires that the death cartificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence of):			
P.O. Box (	at the death certifice by the attending ph tached for use as t	Physician/Me	in the past 12 months?  1 Yes 2 No 9 Unknown	4☐Pregnant at time of death 5☐ 9☐Unknown	⊒Ectopic pregnancy ] Other <i>(specify)</i>		23d. Date of delivery Month Day Year
Records, F	w requires tha been signed should be der	by	Part II. Other significant conditions control  Hypertension; prosta		nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
Vital Rec	Physician: The law this certificate has b al director, page 2 s.	Be Completed	25. Was case referred to medical examiner?			24a. Was an autopsy performed 1 Yes 2 ath Check on one	
Division of \	Attending or death. ector: After by the funer	Certification: To	27. Manner of Death  1 Natural 5 Pending investigation  2 Naccident investigation  3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year)  4-25-05  28e. Place of Injury - At home, farm, str building, etc. (Specify)	28c. Injury at Work?  p M 1 Yes 2 XNo	28d. Describe how in Subject	
]	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai Ce	29a. Certifier (Check only one)  1 Certifying Physic 2 Medical Examine	Residence  ian: To the best of my knowledge, death r: On the basis of examination and/or inv and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	and due to the cause	sh, Maryland p(s) and manner as stated. and place, and due to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	of Ali	29c. License number O. C.M.E.		Date signed (Month, Day, Year) il 26, 2005
			30. Name and address of person who com	pleted cause of death (Item 23a) (Type,	enn Street, Balti	more, Mary	land 21201
~	Sta Registr	53	31. Date filed (Month, Day, Year)  MAY 0 3 2005	22. Registrar's Signature	K)		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16902 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** Marie Adams 4 27 05 3:10AM/Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Heartland Health Care Center - Adelphi Adelphi If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Yeer) **Funeral** Days Months 1□ M 2□XF Hours Director 578-60-8223 84 6-12-1920 Johnston, S.C Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter death with the Marylend nent of Health and Mental Hygiena. or thems 23a or 28e-f shownt: If Item 27 Is marked other than "natural", or items 23a or 28e-f shownt: 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County ir than "natural", or items 23a or 28a-f show the Medical Expressions must be notified at 1X Yes 2 □ No Directo Washington D.C. 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Street. 710 Rittenhouse 20011Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ♥ No 1 □ Never Merried 2 □ Married nore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black ģ 3X Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Smith Betsy Andrews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 1526 Sherwood Ct, Landover, Maryland, 20785 of Disposition (Name of Date 20c. Location - City or Town, State Beverly Thomas Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If Maryland Veteran Cem. 5/4/05 Cheltenham Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Estep Brothers Funeral Ser, P.A. 21. Signature of Funeral Service Licensee 1300 Eutaw PLace, Baltimore, Maryland 21217 23a. Part1. Enter the lisease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Stroke Examiner Physician/Medical Examiner Attending Physician: The law requiras that the death certificate be executed ettending physician and for use es the bunal-trensit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of) vision of Vital Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uee contribute to the cause of death? certificate has been signed by the rector, pege 2 should be datached 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 ☑ No 1 T Yes After this certifical funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 22 No edical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours eftar death.

To the Funeral Director: All completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospita 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4128105 DOOS 4566 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) Phogaville HD, 1220 A East TOP ga Road Seit 230, The Son MD21286

**DHMH 16 Rev 6/95** 

State

Registrar

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3 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 23, 2005 7:35 P. Brown Joann 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's Cheverly Prince George's Hospital Center 5. Social Security Number 577-76-0254 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday). Birthplace (State or Foreign Country) Days 1 □ M 2157 F January 31, 1954 Washington, D.C. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Washington 1∰Yes 2 No D.C. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20010 U.S.A. 3500 14th Street, N.W. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Black 1 ☐ Yes 2 XNo Specify: Specify 3 ☑Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) N/A Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sina Moore James Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3615 Minnesota Avenue, S.E. Washington, D.C. Nicole Wade (Grand-Daughter) 20c. Location - City or Town, State Beltsville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date Chesapeake Crematory, Inc.

May 9, 2005 1 ☐ Burial 2 TCremation 3 ☐ Removal from State \*4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rollins Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4339 Hart Place, N.E. Washington, D.C. 20019 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC ARRHYTHMIA FATAL disease or condition resulting in death) Due to (or as a consequence of): METASTASIS Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗵 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2X No 1 ☐ Yes 2 ☐XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 53209 4-25-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PIERSON CHEVERLY, MD 20185 3001 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar



**Physician** 

/Medical

Examiner

Director

by Funeral

Be Completed

2

Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

**Funeral** 

Director

ould be filed within 72 hours after death with the Maryland Mental Hygiene.

Baltimore, Maryland 21215-0036

Tis marked other than "natural", or items 23a or 28a-f ehow traumatic event, the Medical Exercities from the natifical

and Mental Hygiene.

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic events.

**Physician** 

/Medical

as the burial-transit

detached

the attending physician and

Examiner

The law requires that the death certificate be executed

or Attanding Physician:

To the Hospital

this is

After

within 24 hours after death To the Funaral Diractor: completely filled in by the

Division of Vital Records, P.O. Box 68760.

an	kenship Please Type or Print i						egible.	
	1- State of Mary	-	artment of r rtificate of		ina mentai ny	Reg. No.	005	14904
an	1. Decedent's Name <i>(First, Middle, Last)</i> Robin Blankenship				2. Date of D April		.005 <sup>Year</sup>	3. Time of Death 0116 A. M
er	4a. Facility Name (If not institution, give street and number) 4409 La Plata Ave. Apt. K		4b. City, Town, o Baltimo		of Death	4c. C	ounty of Deati	h
	5. Social Security Number 213-60-3518 6. Sex 1 M 25xF 50	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under: Hours	Min. 8. Date of B (Month, D	irth a <i>y, Year)</i> 6,1954	Co	nplace (State or Foreign untry) yland
_		c. City, Town or Lo Baltimore						10d. Inside City Limits  XYYes 2 □ No
Directo	10e. Street and Number 4409 LaPlata Avenue Apt.	K	10f. Zip Code	211		10g. Citize	n of What Co	
Completed by Funeral Director	11. Marital Status  11. Marital Status  12. Was Decedent Ever Armed Forces?  1 Never Married 2 Married It Yes 2 Married It Yes 2 Married It Yes Charles	in U.S. 13.			gin? (Specify Yes or N , Puerto Rican, etc.)		. Race - Amer Black, White pecifyWhit	e, etc.
ted b	3   Widowed 4   Divorced Year or Dates:	16a, Dece	dent's Usual Occur	ation			of Business/l	
comple	(Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-4or 5+)	life.	kind of work done DO NOT use retire emaker	aunng mosi d)	or working	Ov	n Home	2
To Be (	17. Father's Name <i>(First, Middle, Last)</i> Woodrow Crabson			18. Mothe	r's Name (First, Middle Ethel	e, Maiden St De11s	ımame)	
	19a. Informant's Name/Relationship (Type, Print) Kimberly Smith Daughter	19b. Mailir 424	ng Address <i>(Street</i> 44 Falls	and Numbe Road	or Rumal Route Numb Baltimore	oer, City or 1 , Mary	own, State, Z 'land	ip Code)
	20a. Method of Disposition  1 ☎ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	Ob. Place of Dispo cemetary, crer Lake Viev	esition (Name of matory or other place W Memoria	1	Date 5/2/2005		sburg,	Town, State Maryland
	21. Signatur of Funeral Service Lizensee		2. Name and Addre	ss of Facility	, eitz Funera d, Baltimo	al Hon	e, Inc	. 21211
	23a. Part . Eyer the disease, or complications that caused the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a column of the shock)	death. Do not ent	er the mode of dyir	ig, such as		arrest,	Tyrand	Approximate Interval Between Onset and Death
icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a condition of the c							
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown  23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy			230	d. Date of deliversity	very Day Year
d by Ph	Part II. Other significant conditions contributing to death but no	t resulting in the ur	nderlying cause giv	en in Part I.	23e. Did		•	the cause of death?
Complete					24a. Was auto perfo 1 X Yes		24b. Were aut prior to co death? 1 Yes	opsy findings available ompletion of cause of
To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 □ Inpatient	2 ER/Outpatien	t 3 DOA Oth	ar.	of Death (Check only or sing Home 5 Resi		Other (Speci	ify) (scene)
ation;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation (Month, Day Val	28b. Time of Injury	Four 28c. Injur Wor M 1		28d. Describe Subje	how injury o	as st	elobod and
Sertific	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (Suiding)	At home, farm, stre			281. Location ( City or To	Street and N wn, State)		al Route Number,
Medical Certification:	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my and manner stated.	knowledge, death	occurred at the tir	ne, date and pinion, deat	I place, and due to the h occurred at the time,	cause(s) and pla	d manner as ace, and due t	stated. to the cause(s)
M	29b. Signature and title of certifier	le is	O.C.M	·E.	E	29d. Date s April	igned <i>(Month,</i> 20	, Day, Year) 05
	30. Name and address of person who completed cause of death  RARIA ATCALA	lak tol	) 111 P	enn S	t. Baltimor	e, Ma	ryland	
te ar	31. Date filed (Month, Day, Year)  MAY 0 3 2005	ignature Space	K)					

Registrar DHMH 17 Rev 1/2001

State

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**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician Mary C. Burgee 2005 8:00 A M Apri1 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Home: 819 Scarlett Drive Towson Baltimore County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 29 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days Min. 1 ☐ M 2 € XF 82 Yrs. 1922 220-18-6458 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at Baltimore Co. Towson Maryland 1 ☐ Yes 2x XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 819 Scarlett Drive 21286 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 272No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 201 No Specify: Completed by Specify: white 3℃Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NDT use retired) (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2+ In own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental G. Bates Chaires Sara Jane Miller ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health if StepDaughter Lynn B. Henss 9 LaCosta Court Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or oti XX Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 4/30/2005 Pikesville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burree-Henss-Seitz Funeral Home, Inc. 3631 Halls Road Baltimore, Maryland A En 21211 Approximate Interval Between Onset and Death Pert1. Enter the distributes, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) aspiration **Physician** Preynonia /Medical Due t (or as a consequence of 2° vival encephality months Examiner encephalopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Completed by Physiclan/Medical as the attending IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy jo Dav Year 4☐Pregnant at time of death 5 Cher (specify) the a detached 9 Unknown 9 Unknown ۾ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pg 1 ☐ Yes 2 12 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has director, page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To this 28b. Time of Injury the funeral 27. Manner of Death 1 DNatural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After Hospitel or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident To the Hospitel or Attence within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/28/05 1043936 30. Name and address of person who completed cause of death (Item 23a) (Type. Print)
THOMAS LANSDALE M.D. 6565 N. Charles St. Baltimore, MID 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 0 3 2005

Petert Known Ms Catherine M. Rebell
Baltimore, Maryland 21215-0036

			1 - State C	f Maryland / I	Department of F Certificate of		ental Hygien Reg. N	6000	14906
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	ay Year	3. Time of Death
	/Medic	cal	Catherine Bichell				April 30	2005	7:15 A M
	Examir	ier_	4a. Facility Name (If not institution, give street and nu		211	r Location of Death	4	ic. County of Dea	th
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bi			8. Date of Birth (Month, Day, Yea	-	thplace (State or Foreign
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	and **		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	m or Location				10d. Inside City Limits
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	ems	ner	11. Marital Status 12. Was Dec Armed Fo	edent Ever in U.S. prces?	13. Was Decedent of H	lispanic Origin? (Specan, Mexican, Puerto F	cify Yes or No-	14. Race - Ame Black, Whit	
36	within 72 hours after death with the Maryland ene. then "neturel", or Items 23a or 28a-1 show he Madigal Examinar must be notified at	by Fi	1 Never Married 2 Married 1 Yes If Yes, Gi 3XXWidowed 4 Divorced Year or D	V0	1 ☐ Yes 20XNo	Specify:		Specify:	white
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Z	should and Men marke	은	19a. Informant's Name/Relationship (Type, Print)	191	o. Mailing Address (Street			or Town State	Zin Code)
	and 2 sealth ar n 27 is ner treu		Cathy Oechsler Daughte		O1 Elmwood R				21206
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<u>Ë</u>	Pages ment of 8 ent; If ite ury or o		XX Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)		wn Cemetery	5/4/20	005 Ba	altimore	, Maryland
Baltimore,	permit. Pages 1 and 3 Department of Health Importent; if item 27 any injury or other tro		21. Signature of Funeral Service Licenses	tu	22. Name and Addre Bur ee—Hen 3631 Falls	ss-Seitz 1	Funeral Ho altimore.	ome, Inc	å 21211
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Вох	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as:	Physician/M	23b. Was decedent pregnant in the past 12 months?	come of pregnancy irth 2 Fetal death ant at time of death				23d. Date of del Month	ivery Day Year
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Records,	e law re has bee je 2 sho	Completed					24a. Was an autopsy	24b. Were au	stopsy findings available completion of cause of
Ä		Com					performed?	death?	·
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		104	26. Place of Death	(Check only one)		
of	Phys this al dii	: To	1 ☐ Yes 2 No Hospital: 1 X 27. Manner of Death 28a. Date	npatient 2 ER/Ou	tpatient 3□ DOA Other	4 LI Nursing Hom	e 5 Residence		cify)
on	Attending I r death. ector: After by the funer	tion			njury Worl	k? Yes 2 □ No	od. Describe now jirji	ary occurred	
Division		Certification;	3 Suicide 6 Could not be	of Injury - At home, fa	rm, street, factory, office	28	Bf. Location (Street a		ıral Route Number,
	spitel or A ours after nerel Direc filled in by	Cert	Bullar	ng, etc. (Specify)			City or Town, Sta	18)	
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	Yo th within To th comp	X	29b. Signature and title of certifier		29c. License	e number	29d. D	ate signed (Monti	h, Day, Year)
	4		1 4 guest DO		RES	-000	AP	1 30, 20	25
6	)		30. Name and address of person who completed caus	. 11 . 11					
	Sta	te	Jennifer Wheaten, Sin 31. Date filed (Month, Day, Year) 22. A		of Delta.	or C			
	Registr		MAY 9 3 2005	egistrar's Signature	books				
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1 - For State Registrar	State of Marylan	nd / Department of Health and Certificate of Death	d Mental Hygier	2005 14911/
Physician /Medical	First, Middle, Last)  RNEST BAK  of institution, give street and number)	ER 4b. City, Town, or Location of D	2. Date of Death Month	Day Year 3. Time of Death D. 22. 2005 Hio 7 M
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The road of the ro	E. NORTH AVI			Citizen of What Country?
Some a within 72 hours a syliene.  Soliene.  Completed by (Sbecity Blementary) (Specify Bleme	5. Decedent's Education only highest grade completed)	1 ☐ Yes 2 ☐ No Specify:  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working 16b.	Specify: BLACK Kind of Business/Industry
TO BE STATE OF THE	L BAKER JR.	M	Name (First, Middle, Maid	EMAN
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O Burial 2	Cremation 3 ☐ Removal from State	cometery, crematory or other place)  A  22 Name and Address of Facility	25 P 2005 P 2829 Hi	ALTIMONE MD.
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s a sea A IIII/A-II	ant conditions contributing to death, but not re S, Chnwie Hefall	sulting in the underlying cause given in Part I.		o use contribute to the cause of death?
	d to modical		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
A examiner.	Hospital:	Othog	g Home 5 Residence 28d. Describe how in	
S PAGE T	6 Could not be determined 28e. Place of Injury - At i building, etc. (Spec	nome, farm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	Medical Exeminer: On the basis of examin and manner stated.	owledge, death occurred at the time, date and plation and/or investigation, in my opinion, death of 29c. License number	ccurred at the time, date a	(s) and manner as stated.  Indiplace, and due to the cause(s)  Daty signe - (Month, Day, Year)
Jean Speak	Ell Wagelard III, Nos of person of death (Ite	m 23a) (Type, Print)	04	123/2005
State State Registrar	U TOTOHART, TITUD	6301 N. CHALLES ST lature	BACTIMORLE	9 mD 2/2/2

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	Funeral Director		5. Social Security Number  6. Sex 7. Age (In yrs. last birthday)  Yrs.	Months Days Hours Min. (	Date of Birth Month, Day, Yea	9. Birth Cou 1921 III:	place (State or Foreign ntry)
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should be	nd Mer marke matic	မ	Roy E. Barrett  19a. Informant's Name/Relationship (Type, Print)  19b. Mailin	Julia M. I g Address (Street and Number or Rural Ro		y or Town, State, Zij	Code)
and 2 s	alth ar 27 is er treu			mrose Ave. Baltimor			
Pages 1.	Department of Heal Importent: If Item 2 any injury or other once.		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposicemetery, crem	sition (Name of Date natory or other place)	20c.	Location - City or T	own, State
DAILITION Dermit. Pages	ntmen:		' 4 □ Donation 5 □ Other (Specify) Loudon Par  21. Signatur of Funeral Servic Licensee 22.	k Cemetery May 5, 2 Name and Address of Facility Loudo	005 Balt	timore ci	ty
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UNISION I or Attending	within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	rtific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office 28f.	Location (Street City or Town, Sta	and Number or Run ate)	al Route Number,
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the Ho	in 24 the Fu	ledicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or inv and manner stated.				
10	To To	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month,	- 2
	M		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print)	)	1-5/6	
	2		KENNETH SIBILA MD 78	OI YERY Pd	STE 1	02 2	21204
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 3 2005	NE CONTRACTOR OF THE CONTRACTO			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 30 Day **Physician** 2005 Geraldine Louise Berwager 11:00 aM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3097 Park Ave. Manchester Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Mary Land 6. Sex **Funeral** Months 1□ M 2□(F 79 219-20-0038 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits itam 27 is markad othar than "natural", or itams 23a or 28a-f show othar traumatic evant, the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Carroll Manchester the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3097 Park Ave. 21102 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status s 1 and 2 should ba filed within 72 hours after of Health and Mental Hygiena. Itam 27 Is markad other than "natural", or Ital 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Office Worker Town of Manchester 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harvey E. Yingling Mamie A. Leppo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Wulforst - daughter 3090 LaVerne Ct. Hampstead, Md. 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pagas 1
Department of H
Important: If Ita
any injury or ot 1 → Burial 2 Cremation 3 Removal from State New Lutheran Cem. May 6,2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Manchester, Md. 22 Name and Address of Facility Chapel P.A. 296 Charmil Dr. Manchester, Md. 21102 21. Signature of Fyneral Service Licensee . Heath Elleda 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CHEDIOMYOPATHY disease or condition resulting in death) KEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine ed by the attending physician and detached for use as the burial-transit death certificate be axecuted that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🖼 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown PENDENT DIABETES Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSION ESSENTIAL autopsy performed? 1 ☐ Yes 2 XNo 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 sidence 6 Other (Specify) 1 ☐ Yes 2 📉 No Certification: To 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1SkCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 201663 1000 13/05 1000 core 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 447 EAST VINCER 10000 -JR WECTM, NITER wis. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 03 Registrar 2005

				State of Mary						•	•	3 [	110	10
		•	1 - State Registrar			Cer	tificate of	Death	ר		Rag. No.	10	149	IU
	Physicia	an l	1. Decedent's Name (First, Middle, Last)							2. Date of De Month	ath Day	Year	3. Time of	Death
	/Medic		Willie N.							April	27, 200		4:45	Р М
	Examin	er	4a. Facility Name (If not institution, give s	treet and number)			4b. City, Town, o				4c. County			
	Funeral	-	6060 Sargent Road 5. Social Security Number 6. Sex	7. Age (In	yrs. las	st birthday)	Hyatts If Under 1 Year	If Unde	or 24 Hrs.	8. Date of Bir	Princ	e Geo 9. Birtho	rge's lace (State of try)	or Foreign
	Funeral Director		421-30-9968 <sup>1□</sup>	M 2∑ F	75	Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da SEP 19	, 1929	Ala	bama	
	pu 🔭		Usual Residence of Decedent  10a. State 10b. County	100	c City	Town or Lo	cation					1	0d. Inside C	ity Limits
	Maryla f shore	ō			J. J.,			+ + a <del>.</del>	110				1 🗆 Yes	
	28e-	Director	Maryland Prince C	eorge s			10f. Zip Code	ttsvi	тте	T	10g. Citizen of	What Cour	ntry?	
	death with the Maryland ims 23a or 28e-f show		6060 Sargent Road	, Apt. 104			2078	32			USA			
	ems (	iner		Was Decedent Ever Armed Forces?	in U.S.	13. \	Was Decedent of I	Hispanic C	rigin? (Spe	ecify Yes or No Rican, etc.)	)- 14. Rad Blad	e - Americ k, White,		
36	s afte	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:			☐ Yes 2∏ No				Specif		lack	
Maryland 21215-0036	filed within 72 hours after death with the Marylan Hygiene. other then "naturel", or items 23a or 28e-f show ent. It e Medical Exterding or ust be mailified at	edt	15. Decedent's Educ	ation		16a. Deced	lent's Usual Occu	pation			16b. Kind of B	usiness/Inc	dustry	
22	hin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)		(Give lite. l	lent's Usual Occu kind of work done DO NOT use retire	during mo	ost of worki	ng	Rockla	_	•	
7	ed with	Con		1		0ccup	oational				Hospit			
ng L	ed pla	Be	17. Father's Name (First, Middle, Last)					18. Mot			, Maiden Suman	10)		
2	2 should by and Menta is marked	7	Harry Thornton  19a. Informant's Name/Relationship (Type	ne Print)		19h Mailin	q Address (Street	and Num		e Bankh		State Zin	Code	
	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		Diane Noble/Daughte				Rittenho						•	
ē,			20a. Method of Disposition	20			sition (Name of natory or other pla			ate	20c. Location			
Ē	mit. Pages partment of i cortent; if it injury or o		1 ☐ Burial 2 🕅 Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)	amoval nom State		co Cre	ematory,	Inc			Baltim	ore,	MD	
Baltimore,	permit. Page Department o Importent: If any injury or once.		21. Signature of Funeral Service License			Či	Name and Addre	SOC1	ety c	of MD.	Inc.			
<u></u>	005 e o		Edward A. Grego		dooth	\ Z	99 Frede	LTCK_	koad_	Baltii	more, M	212.	28 Approximat	20
			23a. Part1. Enter the dis ase, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	J.	LO HOL BILL	/1000	an.	is cardiac c	or respiratory a	11051,		Interval Bet Onset and	ween
	Physician '/Medical		disease or condition resulting in death)	Due to lor as a cor	nseque	9//C	EMENE	yey	0	nei	//			
	Examiner		Commentative first manufations	Cono	7778	m	atte	200	101	isoa	use			
	p t	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cor	nseque	nce of	hrill	4	10-	1				
	ecute and I-trans	Examiner	that initiated events cresulting in death) Last	Due to (or as a cor	nseque	nce oily	101/10	11	101	/				
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89	ifficate g phy: as the									1				
Вох	th cert endin	an/M	230. Was decedent pregnant	3c. If yes, outcome of pr			Ectopic pregnanc	ev.	6			te of delive	-	.,
	e dea the att	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time 9☐ Unknown			Other (specify)				Mo	nth	Day '	Year
P.0	The law requires that the death certifica to has been signed by the attending phoage 2 should be detached for use as the	Phy	Part II. Other significant conditions con	tributing to death but no	ot result	ing in the u	nderlvina cause ar	ven in Pan	t I.	23e. Did t	obacco use cont	ribute to th	ne cause of c	death?
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Re	The law te has	Completed								autoj perfo	ormed?	prior to coi death? 1 □ Yes	mpletion of c 2□ No	ause of
ā		Be C	25. Was case referred to medical examiner?					26. Pla	ce of Death	(Check only				
	Physic this co	ပ္	1 □ Yes 2 ▼No	ospital:			1 3LI DOA				dence 6 □Oth		y)	
on	tending Physicien: The leath. tor: After this certificate ha the funeral director, page	tion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea		8b. Time of Injury	Wo	nyat irk? ]Yes 2[		28d. Describe	how injury occur	red		
Division of	or Attending Physicien: after death. Director: Atter this certific in by the funeral director.	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	At hom	ie, farm, str				28f. Location (	Street and Numb	er or Rura	l Route Num	iber,
á	s after of Dire	Certification;	4 Homicide	building, etc. (S)	ipecity)					City or To	wn, State)			
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	(Check only 2 Medical Examin	ician: To the best of my lar: On the basis of exa	ımınatio	edge, death	occurred at the tivestigation, in my	ime, date a	and place,	and due to the ed at the time,	cause(s) and madate and place,	inner as st	ated. the cause(s	s)
	To the I within 2. To the I complet	Med	one)  29b. Signature and title of certifications	and manner stated.			29c. Licen	se number	r		29d. Date signe	d: (Month,	Dav. Year)	
)	N T S		NAR		V	MI	) 21	25/	45		41	28	105	L 2
	1		30. Name and address of person who co	mpleted cause of death	(Item 2	23a) (Type,	Print)				/ /-			
	,		Fitzgerald Birming				ing Stre	et, N	IW, Wa	shingt	on, DC 2	20010		
• *	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 3 20	32. Registrar's S		re K	and s							

		1- Registrar amend item 37 PER FI	aryland / Departs G843 5984	artment of # <b>//05</b> 2temp/	Death		Reg. No.	3. Time of Death
Physic /Med		Joseph H. Bynaker				April 3	30, Day 2005 Year	5:45 PM
Exam	iner	4a. Facility Name (If not institution, give street and number) 8217 Longpoint Rd.		4b. City, Town,	or Location of Deat  Dundall		4c. County of Dea	
Funera Directo		-	e (In yrs. last birthday) 18 Yrs.	If Under 1 Yea Months Days	If Under 24 Hrs		h 9. Bi	nthplace (State or Foreign ountry)
land bw		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
Mary B-f she	ior	MD Baltimore	Dunda	ılk				1 ☐ Yes 2 X No
th with the 23a or 28	al Dire	10e. Street and Number 8217 Longpoint Road		10f. Zip Code 212	222		10g. Citizen of What C USA	ountry?
<b>Baltimore, Interprise Collision 2.12.13-0036</b> permit. Pages 1 and 2 should be lifted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maryland Evanth or mast be multipled at more.	by Funeral Director	11. Marital Status  1 X Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Armed Forces?  1 ☐ Yes 2 X 1 ☐ Yes 2 X 1 ☐ Yes 2 X 1 ☐ Yes 2 X 1 ☐ Yes 7 Give Year or Dates:	No I	Was Decedent of f Yes, specify Cul 1 ☐ Yes 2X No	Hispanic Origin? (S ban, Mexican, Puer Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.
IMBITYIBING Z1Z13-UU30 d 2 should be filed within 72 hours aft th and Mental Hygiene. 77 is marked other than "natural; or traumatic event, Ins Mexical Event traumatic event, Ins Mexical Event	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5	(Give	dent's Usual Occu kind of work done DO NOT use retin	pation a during most of wor ad)	king	16b. Kind of Business School	/Industry
PG 6 B filed I Hygi other vent, I	Be Co	17. Father's Name (First, Middle, Last)	S(	auent	18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	
yidi ould b i Menta varked	10	James Calvin Bynaker Jr.				ynn Will:		
, Widir and 2 sh salth and n 27 is m		19a. Informant's Name/Relationship (Type, Print)  James & Julia Bynaker Pare		-			, City or Town, State, Md. 21222	Zip Code)
<b>SAILLIMOTE,</b> Dermit. Pages 1 ar  Department of Hea  mportant: If item  any injury or other		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  1 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, crer Oak Lawr	natory or other pla		5,2005	20c. Location - City or Dundalk, MI	
Danit. Departition of the properties of the prop		21. Signature of Funeral Service Licensee	The state of the	10 Solle	ers Point	Road, Di	undalk, P. <i>l</i> undlak,Md.	A. 21222
Priysiciai		23a. Pan1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lift immediate Cause (Final disease or condition resulting in death)	the death. Do not ent		ing, such as cardiad	or respiratory ari	rest,	Approximate Interval Between Onset and Death
/Medica Examine		Due to (or as	a consequence of):					
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ificate be executed physician and as the burial-transit	edicai E	d						
ath cert	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnand Other (specify)	y		23d. Date of de Month	livery Day Year
w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death be	ut not resulting in the ur	nderlying cause gi	ven in Part I.		bacco use contribute to	o the cause of death?
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Physician: The Physician: The Physician The Physician The Physician The Physician The Physician	o Be	25. Was case referred to medical examiner?  1 \sum Yes 2 \sum No Hospital: 1 \sum Inpatie	nt 2 ☐ ER/Outpatien	Ot DOA Ot	h	th Check only on		
o	I	27. Manner of Death  1 SNatural 5 Pending 2 Accident investigation  28a. Date of Injur (Month, Day	y 28b. Time of	28c. Inju	4   Nursing H		ence 6 Other (Spe	cify)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Duinde 6 D Could not be	ury - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Si City or Town	treet and Number or Ri n, State)	ural Route Number,
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To th withir To th comp	Me	29b. Signature and title of certifier		29c. Licen			9d. Date signed (Mont	
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)			no Hopkins	Print)	800. 600A	long wor	Street; But	2005 - Wy Wantand 2128
S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registra	r's Signature	hadis	7			- 41601

			1 - For State Ragistrar	State of Marylan		artment of I			400:	14912
			Decedent's Name (First, Middle, Las	"			200117	2. Date of De		3. Time of Death
	Physici /Medio		Harry	Lee		В	right	Aor 1	30 2005	
	Examir	er	4a. Facility Name (If not institution, give			1	or Location of Dea	ıth	4c. County of De	<b>a</b> th
	F		5. Social Security Number 6. Se		last hirthday)	balti If Under 1 Year	MOVO (	s. Date of Bird		Tidle I (Chair
	Funeral Director			M <sup>2□</sup> F 84	Yrs.	Months Days	Hours Mir		y, Year)	Birthplace (State or Foreign Country)  PA
	p .		Usual Residence of Decedent  10a. State 10b. County	100 6	T			12 2	20	
	Aanyla Febor	ō			, Town or Lo					10d. Inside City Limits 1 X Yes 2 ☐ No
	28a-	Director	MD NA  10e. Street and Number	ва	ltimo	10f. Zip Code			10g. Citizen of What	-
	h with		2334 Mosher Str	eet			1216		U.S	
	ams ams	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. \			Specify Yes or No no Rican, etc.)	- 14. Race - Ar	merican Indian,
36	s afte , or It	by Fu	1 Never Married Married	1 □ Yes 2 📉 No If Yes, Give	1	I □ Yes 2√□ No	Specify:	no mean, etc.,	Black, Wi	
9	tural'	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edi	Year or Dates:		lent's Usual Occup	ation			Black
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Athar than "natural", or Itams 23a or 28a-1 ehow ont, the Medical Exemination must be multified at	Completed	(Specify only highest grade Elementary/Secondary (0-12)	le completed) College (1-4or 5+)	(Give	kind of work done  OO NOT use retire	during most of we	orking	16b. Kind of Busines	sylnaustry
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Maryland	be file	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Surname)	
3	shoutd ind Men s marka umatic	은	Franklin W. Bri		401.14.11			Harris		
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ē,	permit. Pages 1 and 3 Department of Health Important: If itam 27 any Injury or othar tra		Carrie L. Brigh 20a. Method of Disposition	C-WIIE	ace of Dispo	IMOSNEY sition (Name of natory or other place	Street	Balt:	1more, Mo 20c. Location - City of	
Ë	Page nent o int: If		1 V Burial 2 □ Cremation 3 □ P  '4 □ Donation 5 □ Other (Specify)	TOTAL OTTAL		d Natio	1	1/05	Laurel,	МА
Baltimore,	ppartmit.		21. Signature of Funeral Service licens	Per C	22	Name and Addre	ss of Facility	1,05	nauteri	Ma
<u> </u>	89 E 29		John B. Ja	Knean for	4	arch F/ 300 Wab	ash Ave	e, Balt:	imore, Mo	21215
ľ			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o		. Do not ente	or the mode of dyin	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
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8760,	death certificate be executed e attending physicien and ed for use as the burial-transit	dicai		d						
9 X	eath certifi attending p	an/Me	IF FEMALE:	3c. If yes, outcome of pregnar	ncv					
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s, p	as this	by P	Part II. Other significant conditions co	ntributing to death but not resu	lting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier 1 Cartifying Physics (Check only one) 2 Madical Exami	sician: To the best of my know nar: On the basis of examination and manner stated.	rledge, death on and/or inv	occurred at the time estigation, in my or	ne, date and place pinion, death occu	e, and due to the curred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	omple	Me	29b. Signature and title of certifier	and manner stated.		29c. License			9d. Date signed (Mon	
	->-0		I Nu	JACHUKWI	J, Mª	0 89	549		4:30	
	5		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, F	Print)				
				chuku c/o 1	Mary	and G	eneral	Hospit	al	
	Stat Registra		31. Date filed (Month, Day, Year) MAY 0 3 2005	22. Registrar's Signatu	ITO CONTRACTOR	S.		*		

-29	60		1 - For Unpend Item	State of 23a, pt.	f Maryland II, 27,2	d / Depa 28a-£	artment of l	lealth and 843 5-17 Death	Mental H -05 tas	ygiene Reg. No	2005	149	13
	Dhysisi		Decedent's Name (First, Middle,			i			2. Date of	Death		3. Time of I	Death
	Physici /Medic		PAULINE			HA	+SE		APRIL	29	·	1017	_Ам
	Examin	er	4a. Facility Name (If not institution, UNION MEMORIAL I	give street and nun HOSPITAL	noer)		BALTIMOR	or Location of Deat	th	40	. County of Deat	n / A	
	Funeral			. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs		Birth Day, Year,	9. Birt	hplace (State or	Foreign
	Director		214-78-9666	1 ☐ M 2 🕱 F	4	/ Yrs.	Months Days	Hours Mili	NOV. I	0 10	63 M	ARYLA	ND
)	tand ow		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation			/		10d. Inside City	y Limits
	72 hours after death with the Maryland naturel', or Items 23a or 28e-1 show Alcal Examinat must be multified at	tor	MARVI AND	NIA			BAL	TIMO	RE C	TI	/	1 XYes	2 🗍 No
	or 28	Jirec	10e. Street and Number	2			10f. Zip Code		-	10g. Ci	tizen of What Co		
	s 23a	rail	135 EAST	2/3/	STREE	=T	Mar Bread and I	212	18	\	451		
10	fter de	Funeral Director	11. Marital Status 1 Never Married 2 Married	Armed For				tispanic Origin? (S an, Mexican, Puer	to Rican, etc.)	NO-	14. Race - Ame Black, Whit		
5-0036	rel', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	e		Yes 225-No	Specify:			Specify: B	LACK	
15-0	ges 1 and 2 should be filed within 72 hours after death with the Maryla t of Health and Mental Hygiene. If item 27 is marked other than "naturel; or Items 23a or 28e-f show or other treumatic event, it a Medical Examinat must be notified at	Completed	15. Decedent's (Specify only highest			(Give	lent's Usual Occup kind of work done OO NOT use retire	during most of wo	orking	16b. K	(ind of Business/	Industry	
2121	filed withln Hygiene. Ither then "	dmo	Elementary/Secondary (0-12)	College (1	-4or 5+)		1	1A KER	2	0	WA) H	OME	
	other	Be C	17. Father's Name (First, Middle, La	ıst)			,,	18. Mother's Na		lle, Maider	- 70		
ylar	should be and Mental is marked o	ToE	WARREN		C	HAS	E	PAULI	NE I	E.	WILL	-IAMS	î
Maryland	12 sh h and 7 Is m treum		19a. Informant's Name/Relationship	1	(arima)	19b. Mailin	g Address (Street	and Number or R					10/
	Health tem 27 other tr		20a. Method of Disposition	ADE 190	20b. Pla	ace of Dispo	Sition (Name of	215151	Date Date	20c. L	ORE HA	Town, State	18
ē	Pages nent of l int: If it		1 ☐ Burial 2 X Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	metery, cren TRO C	REMATO		15-05	13	ALTI HOR	E MARI	WALL
Baltimore,	permit. Pag Department Important: I eny Injury o		21. Signature of Funeral Service Li	censee	11 .			ess of Facility				42 Ital	na
8	9 Q T 9 9		Withich.	N. WU	leam		2140 N	FULTO			ALTO, M		
			23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final	omplications that can be one cause on each	aused the death. ach line.	Do not ente	er the mode of dyir	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Betw Onset and De	een
	Physician /Medical		disease or condition resulting in death)		adone in		ation						
	Examiner				or as a conseque	orice orj.							
	ъ <del>д</del>	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (	or as a conseque	ence of):							
٧	ecute and I-trans	Examiner	that initiated events resulting in death) Last	c	or as a conseque	ance of):							
8760,	cate be executed obysicien and the burial-transit	dicai E		d		, .							
9	tificate ig phys as the	ledic		- 0.									
Box	leath certifics attending ph I for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1☐Live bi	come of pregnandirth 2 Petal of	death 3	Ectopic pregnancy	y			23d. Date of deli	,	∍ar
.O.	at the dea by the al	ysici	1 Yes 2 No	4□Pregna 9□Unkno	ant at time of dea own	ath 5□	Other (specify) _			-	MOTILIT	Day	HAI
Ω.	th be de		Part II. Other significant condition	s contributing to de	ath but not result	ting in the ur	iderlying cause giv	ren in Part I.	23e. Dio	d tobacco	use contribute to	the cause of de	ath?
Vital Records,	quires an sign	ed by	End Stage Renal	Disease					10	Yes 2	No 3□Pr	obably 4 🗆 Ur	iknown
eco	e law requ has been je 2 shoule	Completed							24a. Wa	as an topsy	24b. Were au	topsy findings av	vailable use of
E B		Con							1 ☐ Yes	formed?	death?	2□ No	
Vita	Physiclen: The this certificate rat director, pag	Be	25. Was case referred to medical examiner?  **E Yes 2 \sum No	Hospital:			2X1 DOA Cth	26. Place of De					
of	ng Phys ter this	n: To	27. Manner of Death	28a, Date o	of Injury 2	R/Outpatient 8b. Time of	28c. Injur	4   Nursing F	28d. Describ		6 □Other (Spec ry occurred	unk	
ion	anding l sath. or: After he funer	atio	1 Natural 5 Pending 2 Accident Investigat	4-/4-(		Found 9;25		Yes 2 XNo					
Division	or Atten ifter deat Olrector: in by the	Certification:	3 ☐ Suicide 6 💹 Could no 4 ☐ Homicide determin	ed 286. Place buildin		ne, farm, stre	et, factory, office				od Number of Ru	21st St	<i>⊕r</i> ,
	spitet ours a neral (		29a. Certifier 1 ☐ Certifying	Physician: To the	at home	ledge death	occurred at the tir	me date and place	Baltin			stated.	
	To the Hospitet or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Medical		aminer: On the ba and mann	sis of examination								
	To the comp	Σ	29b. Signature and title of certifier	1	0	4 0	29c. Licens	e number CME			te signed (Month		
	nered		Mullie	the To	rile !	PW)				APRI	L 30, 2	4005	
	1064		30. Name and address of person what NA DU SULTO	D. Ki	rell	111 1	PENN STRE	EET, BALI	CIMORE,	MARY	LAND 21	201	
	Sta		31. Date filed (Month, Day, Year)	1//	egistrar's Signatu	re doce	W						
	Registr	ar	MAY 0 3 20	105 Sent	10 JU	1	1						

			1- State of Maryland /		ent of Health ate of Deatl		ygiene 005	14914
	Physici		1. Decedent's Name (First, Middle, Last)  Mary Cheeseboro			2. Date of I	Death Day Yee	3. Time of Death
	/Medic Examir		4e. Facility Name (If not institution, give street and number)	- hatis		we City	4c. County of Do	
L	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☒ F 87	Yrs. Mon			9. E Day, Year) 3, 1917	Sirthplace (State or Foreign Country) UNK
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Location				10d. Inside City Limits
	a-f sh	ctor	MD Bal	ltimore				1 Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show	Director	10e. Street and Number	1 Of.	Zip Code		10g. Citizen of What	Country?
	ns 23g	Funeral	1217 W. Fayette Street  11. Marital Status 12. Was Decedent Ever in U.S.	13. Was D	2122 acedent of Hispanic C	23 rigin? (Specify Yes or I an, Puerto Rican, etc.)	USA No- 14. Race - Ar	merican Indian,
030	urs after death w al', or Items 23a	by	1 Never Married 2 Married 1 Si No If Yes 2 No If Yes, Give Year or Dates:		specify Cuban, Mexica s 2 No Specify		Black, W Specify:	hite, etc. black
9500-617	be filed within 72 hours after dei ital Hygiene. id other then "natural", or flems event, the Medical Execultural.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0·12) College (1-4or 5+)	(Give kind of	Jsual Occupation work done during mo Tuse retired)	st of working un	K 16b. Kind of Busine	ss/Industry unk
and 21	should be filed within and Mental Hygiene. Is marked other than "aumatic event, Ite Me	Be	unk unk  17. Father's Name (First, Middle, Last)		unk 18. Mot	ner's Name (First, Midd	lle, Maiden Sumame)	unk
ary	s 1 and 2 should f Health and Mer item 27 is marke othar traumatic	P <sub>C</sub>	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Add	ress (Street and Numi	ber or Rural Route Num	nber, City or Town, State	, Zip Code)
Σ,	of Health a of Health a litem 27 is r othar tra		Maryland General Hospital				e, MD 21202	
baitimore	permit. Pages 1 Department of H Important: If ite any Injury or ott		1 □ Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 🛣 Other (Specify) in state	e of Disposition ( etery, crematory	or other place)	Date	20c. Location - City	or Town, State
Dall	permit Depart Import any In		21. Si nature of Eunoral S. wice Licensee Ronal d S. Wade, Director	State Balti	more, MD	Board 655 W 21201	. Baltimore	Street
	Physician		25a. Part Lenter the disease, or complications that daused the death. D shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition				arrest,	Approximate Interval Between Onset and Death
	/Medical- Examiner		resulting in death)  Due to (or as a consequence	ce of):	eart Fo	. 17		
h	LAGIIIII	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence		carr 1-	ame		
ć.	cate be executed obysician and the burial-transit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence	ce of):				
00/00	icate be physici s the bu	dical	d		17.52		A 12-37-42	1
O. DOX	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death	ath 3□Ectopi	c pregnancy (specify)		23d. Date of o Month	lelivery Day Year
ecords, P.	quires that n signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting	g in the underlyin	ng cause given in Part		tobacco use contribute	to the cause of death?  Probably 4 Unknown
Deco	The law re ate has bee page 2 sho	Completed	Diabetes mellitus	unio	ntrollo	24a. We aut per 1 \( \triangle Yes	opsy prior to formed? death	autopsy findings available o completion of cause of
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ician: certific ector,	Be	25. Was case referred to medical examiner?		Other	e of Death (Check only		
0 10	ing Phys	lon; To	27. Manner of Death 1 School 1 School 2 Sea. Date of Injury 28b. Date of Injury (Month, Day Year)	Outpatient 3  b. Time of Injury  M	DOA Other: 4 N 28c. Injury at Work? 1 Yes 2	28d. Describe	sidence 6 Other (Sp e how injury occurred	pecify)
DIVISION	or Attendations after death	ertification:	Accident investigation  3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)			28f. Location	(Street and Number or own, State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after deals for the Funeral Director. After this certific completely filled in by the funeral director,	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowled and manner stated.	lge, death occun and/or investiga	red at the time, date a tion, in my opinion, de	nd place, and due to th ath occurred at the time	e cause(s) and manner e, date and place, and d	as stated. ue to the cause(s)
	To the within To the comp	Me	29b. Signature and tile of certifier $\mathcal{M}\mathcal{D}$ .		29c. License number \$\overline{D00515}\$	743	29d. Date signed (Mo. 4/25/05	
			30, ame and address of person who completed cause of death (Item 23a	a) (Type, Print)	Rubad (	General	4/25/03 Huspita	L
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 0 3 2005	houles	)			

			1- For Amend Item 1 Registrar	State of Ma				-		2005	14915
	Physic	ion	1. Decedent's Name (First, Middle, La	st)				2. Date of D Month	eath Da	ay Year	3. Time of Death
	/Medi		Alton	Lee		Clark		April_	3		6:10 P
	Exami		4a. Facility Name (If not institution, giv				or Location of Death	1	40	c. County of Death	n
		12	3223 Massachuset			Baltimor		-			
	Funeral		5. Social Security Number 6. S	ex 7. Age ⊠M 2□F	(In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D	ay, Year		nplace (State or Foreignstry)
4	Director		219-22-9506 Usual Residence of Decedent		76 Yrs.			August	9,1	928 Nort	h Carolin
	land ow		10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limit
	Mary 1 sh	ţō	MD		Baltin	2020					1 X Yes 2 □ N
	28e	rec	10e. Street and Number		Dalti	10f. Zip Code			10g. Ci	itizen of What Cou	untry?
	within 72 hours after death with the Maryland ene. than "neturel", or Items 23s or 28e-f show he Madical Examinar must be inclifted at	Funeral Director	3223 Massachuset	ts Avenue		2122	9			USA	
	ms 2	Jere	11. Marital Status	12. Was Decedent E	ver in U.S. 13.		lispanic Origin? (Si an, Mexican, Puert	ecify Yes or N	0-	14. Race - Amer	
•	or Ite	Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give	0			o Hican, etc.)		Black, White	o, etc.
	rel', c	þ	3 ₩ Widowed 4 Divorced	Year or Dates:		1 □ Yes 2 🙀 No	Specify:			Specify: B1	ack
	d within 72 ho giene. Ir than "netu	Completed	15. Decedent's Ed (Specify only highest gra	ducation ide completed)	(Give	tent's Usual Occup	during most of won	kina	16b. k	Kind of Business/	
i	within lene. than "	npl	Elementary/Secondary (0-12)	College (1-4or 5-	-)	DO NOT use retire	d)	3			
mai yiaila ElElo 000	D D	S	12th		Floc	r mechan				Carpet	ing
	d tal	Be	17. Father's Name (First, Middle, Last)	1			18. Mother's Nam	,	·	n Sumame)	
2		P	Cary Clark				Lee Anna				
5	2 E S		19a. Informant's Name/Relationship ( Delmonty L. Clar				and Number or Ru				
	s 1 and if Health item 27 other tre			K	20b. Place of Dispo		Highway	130, Si			
	of of		20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	cemetery, cren	natory or other plac	ce)			ocation - City or T	
	permit. Pag Department Importent: I eny injury o		`4 □Donation 5 □ Other (Specif	()	Crownsv		April	11,05	Cro	wnsville	, MD
	Depar Impor eny in		21. Signature of Funeral Service Licer	1500	/ 22	. Name and Addre	ss of Facility 515	1 Balto	o.Nat	tl Pike,	BaltoMD
	20 = 0 a		23a. Part1. Entir the disease, or com shock, or heart failure. List only	/4			Greene Fu			ice	Approximate
	Medical  Examiner  Asician and privial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a	consequence of):  consequence of):						
	death certificate e attending phy: id for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome o  1 Live birth 2  4 Pregnant at ti 9 Unknown	Fetal death 3	Ectopic pregnancy	,			23d. Date of deliv	rery Day Year
	de ad	Ph	Part II. Other significant conditions c	ontributing to death but	not resulting in the ur	iderlying cause oiv	en in Part I.	23e. Did	tobacco	use contribute to t	the cause of death?
	signe signe d be	d by	Endstage renal d	-		, , , ,			Yes 2		
	w requir	ete									bably 4 Unknow
	The lay ate has page 2	Completed	Probable gastroi	ntestinai i	iellorrnage			24a. Was auto perfo		prior to co death?	opsy findings available or properties of the second
	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Unacitali		lav	26. Place of Deat	h (Check only o	one)		
	8 5	P	1 ▼ Yes 2 □ No		t 2 ER/Outpatien		4   Nuising no			6 ☐Other (Special	fy)
	ding Phy h. After thi funeral o	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injun Wor	k?	28d. Describe	how inju	ry occurred	
	I or Attending after death. Director: After I in by the fune	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		y - At home, farm, stre (Specify)		Yes 2 □ No	28f. Location ( City or To		nd Number or Run a)	al Route Number,
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medicel Exem	ysicien: To the best of niner: On the basis of e	xamination and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) date and	) and manner as s d place, and due to	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1 11		29c. Licens	e number		29d. Da	te signed (Month,	Day, Year)
	0		· //	1 /-1	Ny .	OCME			Mav	3, 2005	· )
1	0		30. Name and address of person who of		ath (Item 23a) (Type, I	Print)		111 D			
			Mary G. Ripple, N		y Chief Me	edical Ex	kamıner :	III Pen	n St	., Balto	,MD 21201
	Sta Registr		MAY 0 3 2005	House de St	A CONTRACT						

			For State Registrar	tate of Marylai		artment of H rtificate of L		_	giene Reg. No. 0	05	14916
	Physici		1. Decedent's Name (First, Middle, Last)	BliNN				2. Date of De Month/	Day	Year	3. Time of Death
	/Medio Examir		4a. Fecility Name (If not institution, give street Social Security Number 6. Sex	at the C	eke last hirthday)	4b. City, Town, or	Location of C	4	(		omici
	Funeral Director		214-56-2835		Yrs.	Months Days		Min. (Month, Da	v. Year)	Cour	lace (State or Foreign try) ington, D.C
	Maryland a-f show	tor	10a. State 10b. County Maryland Somerset	10c. C	ity. Town or Lo Prince	ess Anne				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the la or 284 I be not	Director	10e. Street and Number 10585 Clarence Barne	as Poad		10f. Zip Code	1853		10g. Citizen o		itry?
336	hours after death with the Maryland tural', or Items 23a or 28a-f show al Examinar must be notified at	by Funerai	11. Marital Status 1	Was Decedent Ever in U Armed Forces? 1 ⊠Yes 2 □ No KO If Yes, Give	man			n? (Specify Yes or No Puerto Rican, etc.)	)- 14. R	S.A. ace - Americ lack, White, lify: Whi	etc.
Maryland 21215-0036	within 72 ene. than "na	Completed	15. Decedent's Education (Specify only highest grade continuous Elementary/Secondary (0-12)	on	16a. Deced	dent's Usual Occupa kind of work done of DO NOT use retired der	durina most oi	f working	16b. Kind of Business/Industry Ships		
and		Be	17. Father's Name (First, Middle, Last) Jesse Adam Capps					Name (First, Middle,	, Maiden Sum	ame)	
lary	d 2 should by	ဥ	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	ng Address (Street a		or Rural Route Numb		n, State, Zip	Code)
Baltimore, N	es 1 an of Heall fitem 2 r other		June M. Drewer (Sist  20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ Remo  '4 □ Donation 5 □ Other (Specify)	20b.	Place of Dispo cemetery, cren	S. Somers sition (Name of natory or other plac 7 Cremato:	θ)	enue- Cris Date /30/05	20c. Location		wn, State
Balti	permit. Pag Department Important: I any injury o once.		21. Signature ther Service Lice  Robert H. Bradsh	aw, St.	B B	Name and Addres radshaw & 06 W. Mai	Sons	Funeral H	ome	2181	
	Prrysician /Medical Examiner		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one commediate Cause (Final disease or condition resulting in death)	ons that caused the dea ause on each line.  Metastatic  Due to (or as a conse	th. Do not ente	er the mode of dying	g, such as ca		rrest,		Approximate Interval Between Onset and Death
8760,	sate be executed ahysician and the burial-transit	dicai Examiner	Sequentially list conditions, b. cause. Enter Underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a co							
O. Box 6	death certific e attending p od for use as	Physician/Medi	in the past 12 months?	If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)				ate of delive	ory Day Year
<u>α</u>	quires that in signed b uld be deta	by	Part II. Other significant conditions contrib	uting to death but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did t	_	ntribute to th	ne cause of death?
al Records,	n: The law requires that the licate has been signed by the r, page 2 should be detache	Completed						1 ☐ Yes	osy rmed? No	prior to con death?	psy findings available inpletion of cause of
of Vital	Phyaician: This certificated director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hosp	1 Aspatient 2L	] ER/Outpatien	t 3 DOA Othe	36	Death (Check only only only only only only only only		ther (Specify	· · · · · · · · · · · · · · · · · · ·
ion o	ter Ter	1 1	27. Manner of Death 2 Natural 5 Pending investigation	8a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 🗆 Y	rat ⟨? Yes 2 □ No	28d. Describe	how injury occi	ırred	
Division	al or Attendir s after death. al Director: Af ed in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined 2	8e. Place of Injury - At h building, etc. (Speci	nome, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Nun vn, State)	nber or Rura	l Route Number,
	To the Hospital or I within 24 hours after To the Funeral Direct completely filled in b	edicai (	29a. Certifier (Check only one) Certifying Physicis 2 Medical Examiner:	on: To the best of my kn On the basis of examinand manner stated.	ation and/or inv	estigation, in my op	oinion, death o	occurred at the time,	date and place	, and due to	the cause(s)
	To the within To the Comp	Ň	29b. Signature and title of certifier	1) m	$\sim$	29c. License	number	278	29d. Date sign	29_	Day, Year)
	5		30. Name and address of person who comp	eted care of death (Ite	m a) (Type, I	Print)	1733	Selich	, , , , , , , , , , , , , , , , , , ,	is.	2/802
•	Sta Registr		31. Date filed (Month Par Year) 3 200	eted cau of death (Ite	ature A	nedic		5 - 1130	1		

			1- For State of Maryland / Del	partment of Health and Mertificate of Death		2005   4917
	Physic /Med		Decedent's Name (First, Middle, Last)     CHARLES EDWARD CROUSE		2. Date of Death Month	Day Yeer 28, 2005 11:46 P M
	Exami		4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital	4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick
	Funeral Director		5. Social Security Number 217-10-9794 6. Sex 1 🖾 M 2 🗆 F 91 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Jan. 15	9. Birthplace (State or Foreign Mary Tand
	with the Maryland a or 28e-f show	tor	10a. State 10b. County 10c. City, Town or Maryland Frederick Freder			10d. Inside City Limits 1 ☐ Yes ※ No
	ath with the 23e or 28e	al Director	10e. Street and Number 6110 Mt. Philip Road	10f. Zip Code 21703	100	J. Citizen of What Country?
980	or Items	by Funeral	11. Marital Status  1 Never Married  2 Married  1 Never Married  2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 Mo If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🏹 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; injury or other treumatic event, tra Madical Est 2008.	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of workin DO NOT use retired) .nter	ng	Painting Contractor
Maryland 2	uld be filed Mental Hyg Irked othe	To Be C	17. Father's Name (First, Middle, Last)  George Edward Crouse	18. Mother's Name Fanny		iden Sumame)
	and 2 sho ealth and P n 27 is ma		Mrs. Flora B. Crouse, wife 611	ling Address (Street and Number or Rura O Mt. Philip Road,	Frederic	ity or Town, State, Zip Code)
Baltimore,	Pages 1 tment of H tant: If ite		- EDOMARION O EDOMON (Option)/	et Cenetery May 2, 20	05 Fr	c. Location - City or Town, State Cederick, Maryland
Bal	Depar Impor any in		21. Signature of Funcial Service Licensee M00255	<sup>22</sup> Keeneý dand Basford 106 East Church S	d PA Fune t., Frede	eral Home erick, MD 21701
20, 1	Physician and physician and sthe buriat-transit	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Art) that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	nter the mode of dying, such as cardiac o	r respiratory arrest	, Approximate Interval Between Onset and Death
ox 68760,	eath certificate b attending physic for use as the b	/Medical	IF FEMALE: 23h Was decadent prognant 23c. If yes, outcome of pregnancy			
O. B	0 0	Physician/M	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year
Records, P.	en signed	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death.  2  No 3 Probably 4 Onknown
al Reco		Completed			24a. Was an autopsy performed	
Division of Vital	ng Physicie fter this ceri ineral direct	ertification; To Be	25. Was case referred to medical examiner?  1   Yes   2   No			e 6 □Other (Specify)  njury occurred
DIVI		O	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town, Si	
	To the Hospitel or within 24 hours after to the Funerel Discompletely filled in	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Medicel Exeminer: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, ar evestigation, in my opinion, death occurred 29c. License number	d at the time, date	and place, and due to the cause(s)
	+ 3 F 8		) and Mb	D0060417	4	Date signed (Month, Day, Year)
	Sta	te	Hemen Sigh MD 65-6 Thom  31. Date filed (Month, Day, Year)  32. Date filed (Month, Day, Year)	nas Johnson D	r. Fre	device MD 21702
DH	Registr MH 17 Rev 1/20		MAY 0 3 2005 Bosens & Agree			

		aı	State of Maryland / Deparend item #19a per fh g843 5/06/05 fer  1. Decedent's Name (First, Middle, Last)		R	eg. No.	3918
	Physic /Med		JULIANNE CA	RROL	2. Date of Deat Month APRIL	D 14	3. Time of Death 2:10 AM
	Exam Funera	ш	4a. Facility Name (If not institution, give street and number)  COLLEGE MANOR  5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday)	4b. City, Town, or  LUTHERV  If Under 1 Year   If Under 24 Hrs		4c. County of Death  BALTIMOR	
	Director		196-24-1957 1 M XX F 82 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 06-17-	Year) PENNS	e (State or Foreign YLVANIA
	ath with the Marylen 23s or 28s-f show	ctor	MD. BALTIMORE 10c. City, Town or Loc	BALDWIN		10d.	Inside City Limits 1 ☐ Yes 2\( \)\( \)\( \)\( \)\( \)
	ath with th	ral Dire	10e. Street and Number  18 KINCAID COURT	10f. Zip Code 21013	10	0g. Citizen of What Country U. S. A	
020	72 hours after death with the Marylend naturel', or fterns 23a or 28a-f show dical Examiner must be notitied.	by Fune	I Never Married 2 Married 1 Yes 27 7No	/as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerl ☐ Yes XX No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Black, White, etc. Specify: WH	
Maryland 21215-0020	I within iene.	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12 YEARS  16a. Decede (Give k life. December 1) 16b. December 2) 16b. December 2) 16c. December 2) 16b. December 3) 16c. December 3) 16c. December 3) 16c. December 3) 16c. December 3) 16c. December 4) 1	ent's Usual Occupation ind of work done during most of wor O NOT use retired) SECRETARY	king	16b. Kind of Business/Indus	try COMPANY
yland	should be filed ind Mental Hygid i marked other umatic event, ii	To Be	17. Father's Name (First, Middle, Last) JOHN SWANTKO	ANNA	LATZMAN	N	
	1 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		DENISE C. WOLLSHEIMER (DAUGHTER) 18 KI	Address (Street end Number or Ru NCAID COURT, BALDI	WIN, MARY	LAND, 21013	
Baltimore,	permit. Pages 1 ar Department of Heal Important: If Item 2 any Injury or other once.		4 □ Donation 5 □ Other (Specify) HOLY RESURRE	atory or other place) CTION RUSSIAN ORTH.			NASYEVANI
Ba	Depa Impor any Ir		P. S. Letts	Name and Address of Facility CK TOWSON FUNERAL		I OMOON , PIL	
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Park in Serio 5 -	DISEASE	or respiratory arre		proximate erval Between set and Death
	ertificate be executed ding physician end se as the burial-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the consequen				
7.0. 50.	es that the death cer igned by the attendin be detached for use	Physician/N	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23b. Did tob	acco use contribute to the	cause of death?
	ires that the signed by detaction	\$			1 🗆 Yes	B 2 No 3 □ Probably	/ 4 ☐ Unknown
VILAI RECORDS,	The law requires that the death cer ate hes been signed by the attendir page 2 should be detached for use	Completed			24a. Was an performe	ed? availab comple of death	
	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?		1 ☐ Yes		s 2□ No
0 10	Ing Phys After this uneral d	ertification: To	27. Manyer of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of Injury (Month, Dey Year)  28b. Time of Injury		me 5 Resident 28d. Describe how	ce 6 □Other (Specify) v injury occurred	
	oltal or Attend urs efter death ural Director: /	O	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Could not be determined  28e. Place of Injury - At home, farm, street building, etc. (Specify)		City or Town,		
	To the Hospital or A within 24 hours efter To the Funeral Direct completely filled in b	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, death or cone)  1 ☐ Medical Examiner: On the basis of examination and/or invessand manner stated.	ugation, in my opinion, death occurr	ed at the time, date	and place, and due to the	cause(s)
	F 3 F 8		Demlay Loger un	29c. License number  D16619	2	I. Date signed (Month, Dey, And 28, 2005	
2	0 "		30. Name and address of person who completed cause of death (Item 23a) (Type, Prince VERGARA - SOAVES 3CO W. SEMILY 31. Date filed (Month, Day, Year) 3 2005	ni) IPY AVE. LUTHE	eville, M	D. 21093	
	Sta Registra	ie ar	MAY 0 3 2005 32. Registrar's Signature				

DHMH 17 Rev 1/2001

Registrar

05-2997 B.K.S GARY DAUGHTON

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30, 2005 **Physician** APRIL. 2:55 РМ Gary Lee Daughton /Medical 4a. Facility Name (If not institution, give street and number)
UNIVERSITY HOSPITAL 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY N/AIf Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year JUN 21, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex 1X M 2□ F **Funeral** Months Director 214-56-6372 1950 Maryland Usual Residence of Decedent death with the Maryland 10c. City Town or Location 10d, Inside City Limits 10a State 10b County ral', or Items 23e or 28a-f show Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 149 Clyde Avenue 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should ba filed within 72 hours aftar 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify <u>م</u> 3 ☐ Widowed 4 ☐ Divorced White "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 4 Meat Cutter Grocery Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ls marked of Ruth Anna Martin Charles W. Daughton 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lypartment of Health an Importent: If Item 27 Is meny injury or other 2006. Sharon E. Daughton/Wife 149 Clyde Avenue Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 5/2/05 Baltimore, MD 21. Signature of Funeral Services Licensee

Edward A Cregorchik 22. Name and Address of Facility
Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as carding or respiratory arrest, shock, or heart failure. List only one cause on eacy line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Ь. Due to for as a consumence of Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ a No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 2 ☐ No Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 XYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Lo this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 39 05 2 Accident 28f. Location (Street and Number or Rural Route Number, City or L. 11-1. State) Director: 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cluse(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sig. MAY  $_{1}$ , 2005 O.C.M.E ed cause of death (Item 23a) (Type, Pnnt) 11 PENN STREET, BALTIMORE, MARYLAND 21201

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's S

B.K.S

LIZA	BETH DA	RD	State of Maryland / Department of Health and M  Certificate of Death	_	_	14921						
	Physicia /Medic		Decedent's Name (First, Middle, Last)     Elizabeth Hudson Darden	2. Date of De Month APRIL	27,2005	3. Time of Death 12:35P M						
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death BALTIMORE CITY  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bi	4c. County of Dea	thplace (State or Foreign						
	Funeral Director		213-26-0875 1 □ M 2 🕅 F 85 Yrs. Months Days Hours Min.  Usual Residence of Decedent	(Month, Di 10–05–1		h Carolina						
	e Marylan ta-f show	ctor	MD NA Baltimore			10d. Inside City Limits 1 XYes 2 □ No						
	ath with th	Funeral Director	10e. Street and Number 10f. Zip Code 21229		USA							
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Evantral permitting at once.	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Wildowed 4 □ Divorced  1 □ Ves Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Spetif Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ▼ No Specify:	ecify Yes or Ni Rican, etc.)	o- 14. Rece - Ame Black, Whit Specify: Black	te, etc.						
Baltimore, Maryland 21215-0036	vithin 72 hound ne.	Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Name Against ont	ing	16b. Kind of Business Healthcar							
and 21	ld be filed wental Hygierked other t	To Be Co		(First, Middle Whitehur	e, Maiden Surname)							
Mary	nd 2 shoul aith and Me 27 is marl or treumati	ř	19a. Informant's Name/Relationship (Type, Print)  Julius R. Hudson/ Son  19b. Mailing Address (Street and Number or Rura 3042 Grantley Ayenue Balti	al Route Numb	per, City or Town, State,	Zip Code)						
imore,	Pages 1 a tment of Hestent: If item jury or othe			Date	20c. Location - City or Baltimore, MD							
Balt	permit. Departr Importe any inj		21. Signature of Funeral Service Licenses 22. Name and Address of Facility  Wylie Funeral Home 638			imore, MD 2121						
•	Physician /Medical Examiner		Doda to (or as a consequence of):	shock, or hear failure. List only one cause on each line.  mediate Cause (Final sease or condition sulting in death)  a. https://example.com/society/s								
3760, A	ate be executed hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
.O. Box 6	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy  1  Itive birth 2  Fetel death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)  9  Unknown		23d. Date of de Month	livery Day Year						
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use contribute to Yes 2 No 3 P							
I Reco		Completed		24a. Was auto perf 1  Yes	opsy prior to death?	utopsy findings available completion of cause of 2 \square No						
Division of Vital Records, P.O. Box 68	ding Phy h. After this funeral o	To Be	25. Was case referred to medical examiner?  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Hore  The Natural 5 Pending Accident investigation  28a. Date of Injury (Month, Day Year)  Month Day Year)  28b. Time of Injury Work?  1 Yes 2 No	me 5□Res		ocify) AT SCENE						
Divisi	el or Attendi s after death. al Director: A ad in by the fu	Certification:			(Street and Number or Rown, State)	ural Route Number,						
	To the Hospitel or A within 24 hours after To the Funeral Directorpletely filled in by	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the ed at the time	, date and place, and du	e to the cause(s)						
	To To To Com	2	29b. Signature and title of certifier  29c. License number  0.C.M.E		APRIL 27,							
	(0		30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  A COLLA COLLA STREET, BALTIMOR  31. Date filed (Month, Day, Year)  32. Registrar's ignature	E,MARY	LAND 21201							
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's signature  2015									

			1 - For State Registrar	State of Maryl		artment of rtificate of			ene ()	05	14922
П	Physic	ian	1. Decedent's Name (First, Middle, L	ast)				2. Date of Death Month	Day	Year	3. Time of Death
	/Medi		Arthur	S.		Dur	ham	April	23	2005	10:15pM
	Exami	ner	4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town,	or Location of De		4c. Count		
		٠	Clinton Nursir				inton		Prin	ce G	eorges
	Funeral			1XIM 2DE	yrs. last birthday) Yrs.	If Under 1 Yea Months Days		lin (Month Day	Year)	9. Birthpl	ace (State or Foreign try)
	Director		219-80-6469 Usual Residence of Decedent	40	) 11s.			08 19	64	M	D.
	/land		10a. State 10b. County	10c	. City, Town or Lo	cation				10	Od. Inside City Limits
	Man Feb	ţ	MD Prince	Georges	CI	inton					1 ☐ Yes XXNo
	r 28g	lrec	10e. Street and Number	e deorges		10f. Zip Code		10	g. Citizen of	What Count	trv?
	h wit	a D	9211 Stuart La	ane			20735			S.A.	,
	dea	Funeral Director	11. Marital Status	12. Was Decedent Ever i	n U.S. 13. \	Was Decedent of	Hispanic Origin?	(Specify Yes or No- lerto Rican, etc.)		ce - America	
98	or Itu	F	X☐ Never Married 2☐ Married	1 ☐ Yes 2 X No		r Yes, speciny Cui I⊡ Yes 2 <mark>X</mark> No		erro Hican, etc.)		ck, White, e	itc.
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:			э эрвспу.		Specif	<i>y:</i> ]	Black
21215-0036	"nat	Completed	15. Decedent's l (Specify only highest g	Education rade completed)	16a. Deced	lent's Usual Occu kind of work done DO NOT use retire	pation during most of t	working 1	6b. Kind of B	usiness/Indi	ustry
12	withii ene. than	d m	Elementary/Secondary (0-12)	College (1-4or 5+)						17	
9	filed Hygi other	ပိ	11th grade 17. Father's Name (First, Middle, Las	na na		ecurit	<b>1</b>	lame (First, Middle, M		lub	
an	Id be ental kad c	To Be	Thomas Carter					y V. Dur		110)	
Maryland	2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene. Is marked other than "natural", or Itams 23a or 28a-f show surmatic event. If a Medical Exercited at the regulated at	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	a Address (Stree		Rural Route Number,		State Zin /	Codo!
2	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mantal Hygiene. Itam 27 Is marked other than "natural", or Itams 23s or 28s-f show other traumatic evant. If a Medical Evs. Item! as I be notified at		Cynthia Durham	n-Sister				e, Baltim			21207
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than "natural", or Itams 23a important: of the standard other than "natural", or Itams 23a anyl Injury or other traumatic event, the Medical Execution once.		20a. Method of Disposition	20	b. Place of Dispos cemetery, cren	sition (Name of	1 T	Date 20	Dc. Location	City or Tow	vn, State
Ĕ	Page nent o int: If		1 X Burial 2 □ Cremation 3 - 4 □ Donation 5 □ Other (Spec					/29/05 R	andal	lsto	wn, Md
a	permit. Pages Department of H Important: If its any Injury or of		21. Signature of Funeral Service Lice			Name and Addr					
<u> </u>	20 E 20	. 1	Tala n	Jarch	ма 43	00 Waba	n west ash Ave	, Baltim	ore,	Md 2	21215
П			23a Part1. Inter the disease, or cor shock, or heart failure. List only	nplications that caused the d	eath. Do not ente	er the mode of dy	ing, such as card	iac or respiratory arres	t,		Approximate Interval Between
	Pnysician	£ 10	Immediate Cause (Final disease or condition		ardiom	ypathy	(			(	Onset and Death  YEARS
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):						
	LXMIIIIIei		Sequentially list conditions,	b	Hypert	ension				7	(EAR)
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as a cons	sequence of):						
	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):						
8760,	The law requires that the death certificate be executed tee has been signed by the attending physician and bage 2 should be detached for use as the burial-transit			,							
89	ificate g phy as the	edical		d							
Вох	attending for use as	Z .	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre-					23d Dat	e of delivery	,
Ω.	death e atte	hysician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□F 4□Pregnant at time o		Ectopic pregnanc Other (specify) _	У		Mo		ay Year
P.O.	that the d ed by the detached	hys	9 Unknown	9□ Unknown							
S,	res tha igned to be det	by P	Part II. Other significant conditions						cco use cont	ribute to the	cause of death?
ord	w requir been si should	ted	KIDNEY FAILUR					1□ Yes	2 0 No	3 Probab	oly 4 🗆 Unknown
ec C	law law las be	ompleted	OBESITY, OBST					24a. Was an autopsy	24b. V	Vere autops	y findings available pletion of cause of
Division of Vital Records,	: The	Co	OBS TRUCT (V E  25. Was case referred to medical examiner?	SLEEP AP	NEA , V	ENTRICO	LAR TACI	performe	d?   d	leath?	□ No
Vita	Physician: Th this certificate ral director, pag	Be		LIit-li		CARDIA	26. Place of D	eath (Check only one)			FOR STATE OF
of	die	۲.	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2	☐ ER/Outpatient						
on	ling After Tune	tlon	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. înjur Wor M 1 🗆	ryat rk? Yes 2 ∐ No	28d. Describe how	injury occurr	ed	
S	Attending r death. actor: After by the funer	fica	3 ☐ Suicide 6 ☐ Could not b	e One Place of Injury At	thome farm stre		163 2 140	28f. Location (Street	at and Numbe	or Or Oven/ C	Zauta Alumbar
á	afor, after	Certification:	4  Homicide determined	building, etc. (Spe	cify)	or, ractory, orned		City or Town, S	State)	er or murarr	route /vu///Der,
	To the Hospital or Attending Pr within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral		29a. Certifier Certifying Pl	nysician: To the best of my k	nowledge, death	occurred at the tir	me, date and plac	ce, and due to the caus	e(s) and ma	nner as state	ed.
	he Ho in 24 he Fu	edical	(Check only 2 Medical Examone)	miner: On the basis of exami and manner stated.	ination and/or inve	estigation, in my o	pinion, death occ	curred at the time, date	and place, a	ind due to th	ne cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. Licens			Date signed		y, Year)
	./		30. Name and address of person who	Leven		DOC	361642	<	4/25	105	
	h		30. Name and address of person who	completed cause of death (It	tem 23a) (Type, P	rint) RAL	INPER	SINDHU	ANI		
			9131 PISCATA	WAY RD.	CLIN	170N,	MD,	20735			
*	Sta Registr	te ar	31. Date filed (Month, Day, Year) MAY 0 3 2	22. Tegistrar's Sig	B Ap	whi !					

			1- State of Maryland / [	Department of Health and M Certificate of Death	lental Hygie	6000	14923
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici		LARRY SHAWN D	ris Coll		Day Year	21=53 M
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	21 - 2
	Examin	er	HACORD MEMOURAL HOSPITAL			HARFO	0.0
	Formaral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birthol	ace (State or Foreign
	Funeral Director		523-21-4069 XIM 2 IF 38	Yrs. Months Days Hours Min.	(Month, Day, Ye Dec. 9	ear) Count	ry)
			Usual Residence of Decedent		Dec. 9,	1966   COTO	auo
	yland		10a. State 10b. County 10c. City, Tow	n or Location		10	d. Inside City Limits
	Mar F s	tor	Maryland Cecil Per	ryville			1 ☐ Yes 2 🙀 No
	r 28:	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Count	ry?
	h wit		1446 Perryville	21903		USA	
	deat	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - America	
36	be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or items 23a or 28a-f show of other than "natural", or items 23a or 28a-f show event. The Modified Examples or its for multiple	by Fui	1 □ Never Married 2 (2 Married 1   12 Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	Hican, etc.)	Black, White, e	
21215-0036	hour tural	pe t		Decedent's Usual Occupation	165	. Kind of Business/ind	ite
<u> </u>	n 72	Completed	(Specify only highest grade completed)	(Give kind of work done during most of work)	ng	. Kind of Businessand	ustry
12	within ene.	щ	Elementary/Secondary (0-12) College (1-4or 5+)	/Owner	Do	tail Doore	ation
9	Hygid Hygid Sither		17. Father's Name (First, Middle, Last)		(First, Middle, Maid	etail Recre den Sumame)	acion
Maryland	2 should be and Mental Is marked o	To Be	Larry (nmn) Driscoll	Linda		_	
ary	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)	. Mailing Address (Street and Number or Rura	l Route Number, Ci	ty or Town, State, Zip (	Code)
	2 = Z = I		Beth Driscoll / Wife 1	446 Perryville Road.	Perryvill	e. MD 2190	3
ē	s 1 al		20a. Method of Disposition 20b. Place or compate			. Location - City or Tov	
Ë	Page ent c nt: #		1 🗆 Buriai 242 Cremation 3 🗆 Hemoval from State	op Service Corp. 4-30	-05 TO	wson, Mary	land
altimore,	permit, Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licensee	WSOII, FRILY.	Land		
ñ	permi Depa Impo any ir		Alle My Some Down st	McComas Funeral Ho 1317 Cokesbury Roa	me, P.A. d Abinad	on Marvila	nd 21000
			23a. Part1. Enter the disease, or complications that caused the death. On shock, or heart-failure. List only one cause on each line.	not enter the mode of dying, such as cardiac of	r respiratory arrest,	OII, MALYIS.	Approximate
			Immediate Cause (Final				Interval Between Onset and Death
	Fnysician /Medical		disease or condition resulting in death)  a. Due to (or as a consequence	ATION			-
g.	Examiner						
	T KATE	-	Sequentially list conditions, fany, leading to immediate				
	ted nsit	든	cause. Enter Underlying				
•	al-tra	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence	of):			
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687	icate phy: s the	edical	d				
	es that the death certifi igned by the attending I be detached for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	v
Вох	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)			Day Year
o.	the d the ched	ysi	1 Yes 2 No 9 Unknown				
₾.	that ed by deta	Ph /	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	cause of death?
Vital Records,	law requires that the death certifi as been signed by the attending 2 should be detached for use as	d by			1 ☐ Yes	2 No 3 Proba	bly 4 ∐Unknown
Ö	v requir been s should	Completed			24a. Was an	24h Wara autor	ov findings available
3ec	has has	ldm			autopsy performed	prior to com	sy findings available pletion of cause of
<u> </u>	Th date				1□ Yes 2☑		? (C) (C)
=======================================	ding Physiclan: n, After this certific funeral director,	Be	25. Was case referred to medical examiner?  Hospital: 4 (Theoriest of Spice)	26. Place of Death			
of	Phys this al dir	2	1 Impatient 2 TEH/OU	itpatient 3 DOA 4 Nursing Hot		6 ☐Other (Specify)	
Ē.		lo	1 □ Natural 5 □ Pending (Month, Day Year)	njury Work?	28d. Describe how in	1	
Division	Attending r death. sctor: After	Certification:	2 St Could not be	- 02	186 Landing (Charle	-11	Davis Mussian
ĭ	l or Atteno after death Director: I in by the	T.	4 Homicide determined 288. Prace of injury - At nome, ra		City or Town, St		Houle Number,
	urs a		Basement		1446 Per		219070.162
	Hos 24 ho Func felly f	edical	29a. Certifier (Check only goes)  2 Medical Examiner: On the basis of examination an angle angle and manuscrated examination and goes stated.	e, death occurred at the time, date and place, a d/or investigation, in my opinion, death occurr	and due to the cause ad at the time, date a	e(s) and manner as sta and place, and due to t	he cause(s)
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d	Date signed (Month, D	av. Year)
1	7 × 0	_	Da-1 A				
1	XI		mishorm	21809	AI	ML 26, 2	005
	(0)		30. Name and address of person who completed cause of death (Item 23a)	110 ===================================			
			2336 YOAK NO JIMONIC	n MO 2109	3 ,		
	Sta Registr	_	31. Date filed (Month, Day, Year)  MAY 0 3 2005  32. Fegistrar's Signature	Roseles			
	Registr	CI I	HIWI O 9 COOP COOP	• 4			

		1 - For State Registrar	State	of Marylan		artment of He rtificate of D			ene 0 0	5 14	924
Physici		1. Decedent's Name (First, Middle	, Last)	DOF	SE	Y		2. Date of Death Month	- 11	3. Tim	ne of Death
/Medio Examin		4a. Facility Name (If not institution	, give street and n		, , ,	4b. City, Town, or L	ocation of Death		4c. County of I		. 10:1
Exami			Bon Secour	s Hospital			Balti	more		N/A	
Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (Sta Country)	ate or Foreign
Director		219-14-1173 Usual Residence of Decedent		82	2 Yrs.			Mar 31,	1923	Md.	
/land		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation				10d. Insid	de City Limits
Many a-feh	tor	Md.				Bal	ltimore			1 🗆	Yes 2 □ No
ith the Marylar or 28a-1 ehow	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of Wha	•	
ath w		2 North Smallwood					21229			J.S.A.	
landa Itama	Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Marr	Armed F	cedent Ever in U forces? 2 XNo	l.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Sp , Mexican, Puerto	ecity Yes or No- Rican, etc.)		American India White, etc.	n,
or aff	by F	3 XWidowed 4 □ Divorced	If Yes, G Year or	ive .		1 ☐ Yes 2 ☐ <b>X</b> No	Specify:		Specify:	Black	
itied within 72 hours after death with the Maryland Hygiona. Hygiona than "natural", or Itama 23a or 28a-f ehow ont, the Medical Franthermust ternolitied at	ted	15. Deceden	's Education	n	16a. Dece	dent's Usual Occupat	ion wing most of work	ring 1	6b. Kind of Busin	ess/industry	
ithin 7	Completed	Elementary/Secondary (0-12)		/ (1-4or 5+)	life.	kind of work done du DO NOT use retired)			Gord	on Cleane	rs
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should be nd Mental markad o	ဥ	19a. Informant's Name/Relations	<u>-</u>		19b. Maili	ng Address (Street an	nd Number or Rui			ite, Zip Code)	
and 2 and 2		Jeannette Star Wilke	ens		7	809 Jody Knoll	Road Wind	lsor Mill, Md.	21244		
parmit. Pagas 1 and 2 Dapartment of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition			Place of Dispo	osition (Name of matory or other place)	,	Date 2	Oc. Location - Cit	y or Town, Stat	ie
Pagas ment of h ant: If its		1 <b>X</b> Burial 2 □ Cremation `4 □ Donation 5 □ Other (S		n State	Arbu	tus Memorial P	ark	04/28/05	Balti	imore, Md.	
parmit, Dapartri Imports any inju		21. Signature of Funeral Service	Licensee		22	2. Name and Address	of the same of the	ent tilense			
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		23a. Part1. Enter the disease, or shock, or heart allure. List	only one cause	each line.	in. Do not en	ter the mode of dying,	, such as cardiac	or respiratory arres	st,	Approxi Interval Onset a	I Between and Death
Physician, /Medical		Immediate Cause (Final disease or condition resulting in death)	a. 9	cute	KE	5pirat	TURY.	HRRES	t	-	
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	-e	Sequentially list conditions, is any, leading to immediate cause. Enter Underlying	b. Due to	(or as a conseq	quanto of).	DITOUCH	VE 29	179	7 0 0		
cuted	Examiner	Cause (Disease or injury that initiated events	. E	ND S	Stan	Pul,	nondr	Dise	65-2	7-	
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The law requires that the death certific the law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	/Me	IF FEMALE:	23c If yes o	utcome of pregna	ancv				22d Date of	f dolinos:	
attene for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta	al death 3[	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	T delivery Day	Year
tha dy the ched	ysid	1 ☐ Yes _2 Ø No 9 ☐ Unknown	9□Unk	,							
s that	by Pl	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderlying cause giver	n in Part I.	23e. Did toba	icco use contribu	te to the cause	of death?
w raquiras that been signed t should be deta		Congestive	HRQ1	t FA	HLUI	2E		1 ☐ Yes	2 □ No 3 [	Probably 4	Inknown
aw ra	piet	History of	Thorac	otomy	for			24a. Was an autopsy	24b. Wer	e autopsy findi	ngs available
Tha Tha ate ha	Completed	Pulmonary	TUBER	-4/05/	/			perform	ed? deal	th?	
clan: Clan: Octor, pac	Be (	25. Was case referred to medical examiner?						th (Check only one			
Physic this c	은	1 ☐ Yes 275 No 27. Manner of eath		-	ER/Outpatier		4   Nursing H	ome 5 Residen		Specify)	
ding I th. : After funer	tion	1 Natural 5 ☐ Pendin	y ·	nth, Day Year)	28b. Time o Injury	Work?	es 2 🗆 No	20d. Describe riov	injury occurred		
Attan daat daat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could	not be	e of Injury - At h	ome, farm, st	reet, factory, office		28f. Location (Stre	et and Number o	or Rural Route I	Number,
alor /	Certification:	4  Homicide determ	buil	ding, etc. (Specia	fy)			City or Town,	State)		
To the Hospital or Attanding Physician: Tha law within 24 hours aftar daath. To the Funaral Director: After this certificate has completely filled in by the funaral director, page 2	edical C	(Check only 2 Medical	g Physicien: To the	ne best of my kno	owledge, deat	h occurred at the time vestigation, in my opin	a, date and place, nion, death occur	and due to the cau	ise(s) and manne e and place, and	or as stated.	ise(s)
the hin 24 the F	Medi	one)	and ma	nner stated.		29c. License			d. Date signed (A		
vit To		29b. Signature and title of certifie	Medical Mil DIN	Prysic	-100	7 1	2761		24-24		
5		30. Name and address of person	who completed co	) I U	m 23a) (Tuno	Print)	5 4 7 /		7-0	- 200	J.
3		FAHamilta		000 W. 7		more Str	eet, BA	LTIMURE	HD		
Sta		31. Date filed (Month, Day, Year)		Pajistrar's Signa		had 5		,			
Registr	rar	MAY 0	3 2005	Melier	D 19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#26.perMD G843.5/3/05 TT State of Maryland? Department of Health and Mental Hygierle [] [] 5 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6:15 AM **Physician** April 27 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Timonium **Baltimore** 20 Salthill Ct. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☐ F Yrs. Nov. 29 1910 MD Director 94 217-12-9070 Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show rai', or items 23a or 28a-f show Exeminer must be notified at 1 ☐ Yes 2 No Director Timonium MD Baltimore 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number USA 20 Salthill Ct. 21093 Funerai 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other then "nature traumatic event, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. 12 Secretary State Government n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fite Department of Health and Mental Hy Important: If Item 27 is marked oth any july or other traumatic event 2008. Be Mary E. Dailey Ambrose J. Kennedy 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) M. Cara Erskine/daughter 20 Salthill Ct., Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a Method of Disposition 1 → Buriai 2 □ Cremation 3 □ Removal from State National Cem. | 5/2/05 \*4 ☐ Donation 5 ☐ Other (Specify) Balto. Balto., MD Lemmon Funeral Home of Dulaney Valley, 21 Signature of Juneral Ser Bryan W. Clar 10 W. Padonia Rd., Timonium, MD 21093 23a. Part1. Ent-r the disease or complications that shock, or heart failure. List only one cause or Immediate Cause (Fhal disease or constitutions) ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** soliation resulting in death) /Medical a consequence of) **Examiner** Sequentially list conditions, if any, leading to init rediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? abrillation 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1 Yes No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ← Heme → Residence 6 □Other (Specify)

FIX TO HE JOH ASIS 23 P.O. Box 68760, certificate SIL After 1 Attending death. after death Hospital or

the

in by the funeral within 24 hours aft To the Funeral Di completely filled in

Certification: To

Medical

30. Name

5 Pending investigation

6 Could not be determined

1 ☐ Yes 2 No

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

29c. License number

28c. Injury at Work?

1 □ Yes 2 □ No

3□ DOA

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Sule 200

28d. Describe how injury occurred

Mot 31. Date filed (Monti

32. Fegistrar's Signatur

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient

28a. Date of Injury (Month, Day Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Emily R. Evans 4:20 PM April 2005 30. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Annapolitan Assisted Living Facility Arnold Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG 25, 19 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 X F Director 197-34-4297 1909 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits in is marked other than "natural", or itams 23a or 28a-f show treumatic event, the Medical Exactiver most be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 84 N. Old Mill Bottom Road 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 T√Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Retail permit. Pages 1 and 2 should be filed with Department of Heath and Mental Hyglene Important: If item 27 is marked other that any liqury or other treumatic event, I.v. 120.169. Business Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 Walter Raffels Mabel Fulmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn E. Mach/Daughter 631 Andrew Hill Road Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 5/2/05 Baltimore, MD 21. Signature of Funeral Service Licensee

Edward A Gregorchik Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Jem er Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or Jorynia Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a cons y uence of) attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 → No Medical Certification; To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending s after death, if Director: Af id in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May 2, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1667 Orofton 6 M Nuscirce h( 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ALVERTA

EDMONSTON,

P.M

7:30

2005

27,

within 24 hours a To the Funeral C Medical State Registrar

29a. Certifier (Check only one)

31. Date filed (Month, Day, Year) " --

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT, M.D.

W 2300 DULANEY VALLEY ROAD

29c. License number

29d. Date signed (Month, Day, Year) 2005

TIMONIUM 21093 MD

32. Registrar's Signature Steen & Speak Kurt Fulp, Jr. 05-03033 RPD

)			State of Maryland / De State of Maryland / De	partment of Health and M e <b>18</b> 14 to -28 05 tras	lental Hygien	2005 14928
	Dhusisi		1. Decedent's Name (First, Middle, Last)	C. 0 =	2. Date of Death Month	3. Time of Death
	Physicia /Medic		KURT CARLOS	7-1-1	May 2, 200	
7	Examin		ta. Facility Name (If not institution, give street and number) University Hospital	4b. City, Town, or Location of Death Baltimore	4	ic. County of Death
53	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birtho	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea AUG · 31, 1	9. Birthplace (State or Foreign Country) 984 MARY LA-WO
4)	rland Iow		10a. State 10b. County 10c. City, Town o	r Location		10d. Inside City Limits
	a-f sh	ctor	MARVIANS N/A	BALTIHORE	CITY	1,X Yes 2 □ No
	ith the	Director	10e. Street and Number	10f. Zip Code	/10g. C	Citizen of What Country?
	sath w		11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spe	acify Vas or No-	14. Race - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or items 23e or 28a-f show any injury or other traumatic event, I'm Medical Examiner: ust be notified at once.	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto  □ Yes 2 No Specify:	Rican, etc.)	Black, White, etc.  Specify: BIACK
21215-0036	72 hou			ecedent's Usual Occupation ive kind of work done during most of work		Kind of Business/Industry
215	ithin 7 19. 19. "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)	-	300 40. 1
121	iled w tygier her th		12 HGRADE 17. Father's Name (First, Middle, Last)	REP COOK	(First, Middle, Maide	BACKFIN (SUMAMA)
Maryland	d be fantal becaded	To Be	KURT CARLOS FULP SR.	MARIL	FI) A	SPRIGGS
ary.	shoul nd Me mark	F		ailing Address (Street and Number or Rura	al Route Number, City	
	and 2 alth a 27 is er tra		KURT C. FULP SR. (FATHER) 14	08 MOUNTHOR COU	RT, BALT.	THORE MD. 21217
Baltimore,	of He of He if item		cometerv	crematory or other place)		Location - City or Town, State
Ĕ	Pag tment tent: i		'4 □Donation 5 □Other (Specify) KING	LEMORIAL PARK 05-6	7-05 W	ODDLAWN, MARYLAND
Bal	permit. Pa Departmen Importent: any injury		Territor 1	2140 N. FULIO	NAVEIX	ODDLAWN, MARYLAND FUNERAL HOME BALTO, MD. 21217
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injurie			
	/Medical Examiner		Due to (or as a consequence of)			
Ш		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events			
90,	cate be executed physician and the burial-transit	I Ex	resulting in death) Last Due to (or as a consequence of)			
928	cate be physicia the but	dicat	d			
O. Box 6	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
, P.O.	requires that the een signed by th hould be detache	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Division of Vital Records,	quires n sign uld be	ed by			1 ☐ Yes	2 No 3 Probably 4 □Unknown
000	law red as bee 2 shot	Completed			24a, Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
8	The ate has page	Com			performed?	death?
/ita	ysician: is certific director,	Be	25. Was case referred to medical examiner?		h (Check only one)	
of \	S D	-T	1X Yes         2 □ No         Hospital:         1 ☑ Inpatient         2 □ EF/Outp.           27. Manner of Death         28a. Date of Injury         28b. Tim			6 □Other (Specify) jury occurred Operator of a
o	ding Phys th. After this funeral di	tlon	1 Natural 5 Pending (Month, Day Year) Inju	ry Work?	bicycle St	ruck by a Motor
İSİ	Atten r deal sctor	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm		Vehicle 28f. Location (Street	and Number or Rural Route Number,
ā	tel or rs afte el Dir	Certification:	Scene building, etc. (Specify)	<u> </u>	St. At Str	and Number or Rural Route Number, ate) 1500 Block Presstma icker St. Balto., Md
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Medical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, control on the basis of examination and/control on the basis of examination and control on the basis of examination and control on the basis of examination and control on the basis of examination and control on the basis of examination and control on the basis of examination and control on the basis of examination and control on the basis of examination and control on the basis of examination and control of examination and control on the basis of examination and control on the basis of examination and control on the basis of examination and control on the basis of examination and control on the basis of examination and control on the basis of examination and control on the basis of examination and control on the basis of examination and control on the basis of examination and control on the basis of examination and control on th			
	To t To t	Σ	29b. Signature and title of certifier	29c. License number OCME		Date signed (Month, Day, Year) y 2, 2005
_			30. Name and address of person who completed cause of death (Item 23a) (Ty	111 Penn Stre	eet Balti	more, Maryland 21201
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 0 3 2005  32. Figistrar's Signature	hout		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 29, 2005 **Physician** Month PRIL Richard A. Frederick 6:18 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, May 22, 19 5. Social Security Number 6. Sex **Funeral**  Birthplace (State or Foreign Country) 1 ☑ M 2 ☐ F 215-32-9829 Director Maryland Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic avant. If a Madical Examiner must be notified at Directo Maryland Baltimore 1 ☐ Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a or 9926 Britinay Lane 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced neturel Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Self-Employed Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade Plumber 12 should be filed w h and Mental Hygier 7 is markad other th Plumber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be thento of Health and Menta tent: If item 27 is marked C. Wesley Frederick Maru Griffith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. D. Diane Frederick (wife) 9926 Britinay Lane, Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 5/3/2005 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 4 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARCINOMA OF THE COLON /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the first line of the cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) sician and burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? res 200 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To tha ! 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04-79-05 D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHOO, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 State Registrar

			1 - For Stete Registrar	State of	Maryla	nd / Depa	artmen <i>rtificat</i>			and M		giene Reg. No.	005	14930
			1. Decedent's Name (First, Middle, La	ist)							2. Date of De	ath		3. Time of Death
	Physic /Medi		Alfred		L.		Frai	nks			Month	Day 29	2005	3:56 PM
7	Exami		4a. Facility Name (If not institution, gire	ve street and num	ber)		4b. City,	Town, or	Location of	of Death			County of Death	
			Union Memoria	l Hospita	al		Ba	alti	more				NA	
	Funeral		5. Social Security Number 6.	Sex 7	. Age (In yr:	s. last birthday)	If Under Months		If Under :	24 Hrs. Min,	8. Date of Bir (Month, Da	th Voor)	9, Birth	place (State or Foreign
	Director		213-30-3030	1□M <b>2</b> √□F	62	Yrs.	Monas	Days	riours	WIKI,	7-20		Cou	Md.
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. C	City, Town or Lo	cation							1011-11-01-11
	Manyl f sho	ō	Md. Anne	Arundel		Glen		e						10d. Inside City Limits 1 Yes 2 □ No
	28a	Director	10e. Street and Number				10f. Zip	Codo				12 0'''		
	3a or		7861 Crilley Roa	Ant	. 419			21061	ı				en of What Cou	ntry?
	death ms 2:	Funeral	11. Marital Status	12. Was Deced	ent Ever in					rin? (Sne	or No		ISA I. Race - Americ	can Indian
9	after or fter	골	1 ☐ Never Married 2 ☐ Married	Armed Ford	No No		f Yes, spec	ify Cuba	n, Mexican	, Puerto	ecify Yes or No Rican, etc.)		Black, White,	
8	72 hours after death with the Maryland naturel', or Items 23a or 28a-1 show diseal Examinat must be rodified at	by	3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Dat			1 ☐ Yes	No D	Specify:			5	Specify: Bla	ack
5	be filed within 72 hours after death with the Manylan Ital Hygiene. Id other then "naturel", or Items 23a or 28a-f show event, the Medical Evantiner must be rediffed at	Completed	15. Decedent's E (Specify only highest gro	ducation		16a. Deced	dent's Usua	d Occupa	ation	of work		16b. Kind	d of Business/In	dustry
2	within ene. then "	idu	Elementary/Secondary (0-12)	College (1-4	tor 5+)				luring most )	OF WORK	ng			
2	e filed within If Hygiene. other then vent, I've Me		12th grade			Mai.	l Han	dler						l Service
Maryland 21215-0036	ntal Hed of	Be c	17. Father's Name (First, Middle, Last Soloman	,	Eve	nlea					(First, Middle,	Maiden S	,	
2	should be nd Mental marked umatic ev	ဥ	19a. Informant's Name/Relationship (	Type Print)	FLC	anks	a Address	(Ct		udin			Harde Town, State, Zip	
	nd 2 lith a 27 is		Dorothy Franks	Edwards	Ex-V	Vife I	P.O. 1	Box	1594,	Gle	n Burni	e, Mo	10wn, State, Zip 3. 2106	
Baltimore,	s 1 a		20a. Method of Disposition			Place of Dispo cemetery, cren	sition (Nam	ne of			ate		ation - City or To	own, State
Ĕ	9 + 1 0		1 Burial 2 Cremation 3 C 1 Donation 5 Other (Special		ate	Arbutus				5-4-	05	Arhi	utus, Mo	٦
aĦ	Department Parent Importent:		21. Signature of Funeral Service Lice	nsee					s of Facility				ce, Md.	21202
<u> </u>	Dep Imp		1 & lady	War	حي		Marc	h F.	H. Ea	st			North Av	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau	sed the dea	th. Do not ente	er the mode	of dying	g, such as c	ardiac o	r respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			ENCE	PHELO	PAT	HY					Onset and Death
	/Medical Examiner		resulting in death)	u	as a conse			- • • •						10 DH42
	Cxammer	L	Sequentially list conditions,	b		ZURES								TO DAYS
7	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a conse	-								
V	and and II-trar	хап	that initiated events resulting in death) Last	U	RSA as a conse	PNEU	MON	(A)						7 DAYS
68760,	ficate be executed physician and s the burial-transit	aiE			COH	'	JOSE							om vinans
	ficate g physics the	edicai		. d		110	30.30							20 YEARS
Вох	eath certif attending for use a	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								220	d. Date of delive	D.
<u> </u>	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnan			Ectopic pre Other (spe					200		Day Year
О	at the by th tache	hys	9 Unknown	9□ Unknow										
Ś	The law requires that the death certifite has been signed by the attending vage 2 should be detached for use a	by Physician/M	Part II. Other significant conditions of	ontributing to deat	h but not res	sulting in the un	derlying ca	use givei	n iπ Part I.		23e. Did to	bacco use	contribute to th	e cause of death?
Records,	w requir been si should	ted									1 🗆 Y	es 2 24	No 3 ☐ Proba	ably 4 Unknown
ec	has by	pie									24a. Was a	in 2	24b. Were autop	osy findings available of
		Completed									perfor	med?	death?	2 No
Viital	siclan: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	11. 2.1				-	26. Place o	of Death	(Check only on			
0	Phys this al dir	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 X Inp		ER/Outpatient			4 🗀 Nurs				Other (Specify	)
5	ding f	ion	1 Natural 5 ☐ Pending		njury Day Year)	28b. Time of Injury		c. Injury Work	?		8d. Describe ho	ow injury o	ccurred	
Division of	death death ctor: A y the fu	licat	2 Accident investigation 3 Suicide 6 Could not be		Injuny - At h	ome, farm, stre	M ot footon.		es 2 □ No		0f I (O			_
	after after Dire	Certification;	4 Homicide determined	building,	etc. (Specia	fy)	et, lactory,	OHICE		2	City or Town	reet and N 1, State)	iumper or Hurai	Route Number,
	spite hours inerei y fille		29a. Certifier 1 Certifying Ph	ysicien: To the be	st of my kno	owledge, death	occurred a	t the time	a, date and	place, ar	nd due to the ca	ause(s) an	d manner as sta	ated
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	Medical	(Check only 2 Medical Exen	niner: On the basis and manner	s or examina	ation and/or inve	estigation, i	n my opi	nion, death	occurre	d at the time, d	ate and pla	ace, and due to	the cause(s)
1	With To t	Σ	29b. Signature and title of certifier				29c.	License	number		2	9d. Date s	igned (Month, E	Day, Year)
			VEGN	Joll	MOD			943	1894	6-E	37 A	PRIL	29,20	005
	4		30. Name and address of erson who											
	-01		PARUL AGARWAL, 31. Date filed (Month, Day, Year)		EAS	LUNIVE	ERSIT	Y PF	ARKWI	AY, E	BALTIMO	RE, I	MARYLAN	JD 21218
	Stat Registra		MAY 0 3 20	05	Suar s Signa	ture	de l'							

			1 _ State	State of Maryland		rtment of F			tos U U U	14931
			Registrar     Decedent's Name (First, Middle, Last)			imouto or	Dou.,	2. Date of Deat		3. Time of Death
	Physicia /Medic		Richard Fe	1+5				O T	Z9 ZW	S12:10M
	Examin		4a. Fecility Name (If not institution, give st	reet and number)		4b. City, Town, o	r Location of Death		4c. County of De	ath
			Bayrien Med	rical Cent		If Under 1 Year	If Under 24 Hrs.	C Data of Birth		Sisterile - (Ote to 1971)
	Funeral Director		5. Social Security Number 6. Sex 213-34-4395	M 2□F 7. Age (In yrs. la	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan. 27	Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent					Jan. 27	, 1957 PM	
	show det	L	10a. State 10b. County	10c. City	, Town or Loc	cation				10d. Inside City Limits 1 XYes 2 □ No
	88-1:	Directo	Maryland   Harford	A	berdee				Og. Citizen of What	
	with t a or 2 Lbs.n		10e. Street and Number 6 Wilson Avenue			10f. Zip Code 21001		'	USA	Country?
	has 23	Funerai		2. Was Decedent Ever in U.S	S. 13. V	Vas Decedent of H	lispanic Origin? (Spe	cify Yes or No-	14. Race - Ar	merican Indian,
٥	should be filed within 72 hours after death with the Maryland di Mental Hygiene. marked other than "natural; or items 23a or 28a-f show marked other than "natural; or items 23a or 28a-f show matic event, Ira Medical Examinar must be notified at		1 ☐ Never Married 2 🔀 Married	Armed Forces?  1 XYes 2 □ No If Yes, Give		Yes, specify Cuba	an, Mexican, Puerto F Specify:	Rican, etc.)	Black, W	hite, etc.
21215-0036	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 1955-	·8T		. ,			White
7	"natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give I	ent's Usual Occup kind of work done OO NOT use retired	during most of working	ng	16b. Kind of Busine	ss/Industry
212	withi	omp	Elementary/Secondary (0-12)	College (1-4or 5+)			re Special	ist	U.S. Gov	ernment.
ַ	filed Hygothar othar	Be C	17. Father's Name (First, Middle, Last)		1 1011111		18. Mother's Name			J. 11110110
/ <u>a</u>	should be filed within 72 ind Mental Hygiene. I markad othar than "nat umatic evant, Ira Medic	To B	Baker (nmn)	Felts			Mildred	(nmı	n) Gr	ay
Maryland			19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Street	and Number or Rura	Route Number	City or Town, State	e, Zip Code)
	es 1 and 2 of Health of item 27 i		Brigitte M. Felts - 20a. Method of Disposition		6 Wil	SOC Aver	we, Aberdo		21001 20c. Location - City	or Town. State
ğ	m O		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	metery, crem	natory or other plac	1			C. D. K. Z.
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Sign by other rap Server License			Ervice C Name and Addre	corp. 5-2-0		Cowson, Ma s Funeral	Home, P.A.
ñ	Dep Imp		THE THE	#=	1 1	.317 Coke	sbury Road			yland 21009
	-		23a. Part I. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death e cause on each line.	. Do not ente	er the mode of dyir	ng, such as cardiac o	r respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	respira-	tory	failur	-6			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):		0			741-03
		er	Sequentially list conditions, b.	Due to (or as a consequ	lence of):	-01101	<u>e</u>			ZINOUIS
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	OWEC	PXto	enity	ischemi	$\alpha$		24 hours 5 days
o,	an an		resulting in death) Last	Due to (or as a consequ						J
8760	cate be executed physician and the burial-transit	dicai	d.							
9		an a	IF FEMALE:	c. If yes, outcome of pregnar	ncv				22d Data of	dolivany
Box	that the death certifii ed by the attending of detached for use as	Physician/M	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 🗌	Ectopic pregnancy Other (specify)	y		23d. Date of a	Day Year
o.	oy the	hysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown						
o, o	The law requires that the death certifi tie has been signed by the attending rage 2 should be detached for use as	by P	Part II. Other significant conditions cont	ributing to death but not resu	Iting in the un	nderlying cause giv	ren in Part I.	23e. Did tob		to the cause of death?
ğ	w require been sig should b							1 □ Ye	s 2 No 3	Probably 4 Hunknown
Records,	law r nas be	Completed					<del></del>	24a. Was a autops	y prior t	autopsy findings available o completion of cause of
	cate l								No 1 TY	
Vital	ysician: The law is certificate has t director, page 2 s	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 npatient 2 = E	ER/Outpatien	t 3 DOA Ott	26. Place of Death		e) ince 6 □Other (S	-acifel
10	g Phy er this eral d	<del> </del>	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur			w injury occurred	Decity)
lol	ath. or: Aft	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		Yes 2 □ No			
Division of	or Atter ter de lirecto n by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office	2	8f. Location (St. City or Town		Rural Route Number,
	pital ours a serai C		29a. Certifier 1 Certifying Phys	ician. To the hest of my know	viedne death	occurred at the ti	me date and place a	and due to the ca	ause(s) and manner	as stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica	edical	(Check only 2 Medical Examin one)	ician: To the best of my know er: On the basis of examinati and manner stated.	ion and/or inv	estigation, in my o	opinion, death occurre	d at the time, da	ate and place, and o	ue to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	0. 0 0		29c. Licens	se number	2	9d. Date signed (Mo	onth, Day, Year)
	11		Sumil	Singital		R	ES-00	00	4/29/20	05
	75		30. Name and address of person who cor				. 0	•	100	
	Sta	ite:	31. Date filed (Month, Day, Year)	32. Paistrar's Signat	a He	AU	e.,Balt	100CIR	-, MD	11221
	Registi		MAY 0 3 2	32. Registrar's Signat	K A	gode)				

amend item, 17, per Int in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day, Month Year **Physician** Faison В. 30, 45 P M Linda Zuos /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner of Hospit.1 Ballmore City Sinci Baltmore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O4 29 50 7. Age (In yrs. last birthday)
Yrs. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex **Funeral** 1 □ M X X F Director 214-54-7456 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show the Mudical Examinant has be notified at XXYes 2 □ No Director Baltimore MD NA Faisi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 2402 Loyola Northway Apt 104 21215 U.S.A. Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married ō 21215-0036 1 ☐ Yes 2√2 No Specify: Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Black "neturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th grade na Cosmetician School 17. Father's Name (First, Middle Last) Montgomery treumatic event. 25 land 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be Arthur W. Montogomery Lillian Speed Know 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is any injury or other treu once. 2402 Loyola Northway Apt Balto, 301, Teir Faison-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 5/6/2005 Arbutus, Md 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Partil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Due to (1 r as a consequence of): Zyeas /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner use as the burial-transit The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy been signed by the atte should be detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DISCOSE page 2 autopsy performed; certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No of Vital or Attending Physicien: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 얼 1 ☐ Yes 2 X No 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After Division 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation in by the within 24 hours after deat To the Funerel Director: 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospitel completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 April 30, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H050.7.1 Wheaton Sinci Jennitor 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 3 2005

			. For	State of Mary	land / Departm	ent of Health and N	Mental Hygier	_	11000
			1 - State Registrar		Certific	ate of Death	Reg. I	2005	4933
	Physici		1. Decedent's Name (First, Middle, L	ast)	FAUL	KNER		Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)		city, Town, or Location of Death		4c. County of Deat	
			BON SECOUL		TAL B	Altimore		NIA	
	Funeral Director		5. Social Security Number 6.  228-28-8-842  Usual Residence of Decedent	Sex 7. Agy (Ir 1 □ M 202F 7 7	yrs. last birthday) If Ul Mon	ider 1 Year If Under 24 Hrs. hs Days Hours Min.	8. Date of Birth Month, Day Yea	927 9. Bin	thplace (State or Foreign puntry)
	how		10a. State 10b. County	10	c. City, Town or Location				10d. Inside City Limits
	the Ma 28a-f s	Director	10e. Street and Number	A	BATTI mo	RE Zip Code	100 (	Citizen of What Co	1 Pres 2 No
	h with	al Dir	1400 FASTI	nachison "	5+550	21205	109.	11. K.	4
	ams ams	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13. Was D	ecedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame Black, Whit	erican Indian,
5-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show itsal Examinar must be rodified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 WNo If Yes, Give Year or Dates:		s 2 No Specify:		Specify: 3	BLACK
15-0		Completed	15. Decedent's E (Specify only highest g		16a. Decedent's (Give kind o	Jsual Occupation work done during most of work Tuse retired)	king 16b.	Kind of Business	/Industry
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and	al Hyg	BeC	17. Father's Name (First, Middle, Las	1)		18. Mother's Nam	ne (First, Middle, Maide	en Sumame)	
yla		To		4ulkner		EllA	Johns		
Maryl	d 2 should th and Men 7 is marks traumatic		19a. Informant's Name/Relationship		19b. Mailing Add	ress (Street and Number or Rui	Rasti	4 - 6	1 3 . 5 -
ล์	s 1 and if Heali itam 2 other		MARGARE 20a. Method of Disposition		Ob. Place of Disposition cemetery, crematory		The state of the s	Location - City or	Town, State
E O	Page nent o int: If iry or		1 ■ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec	Removal from State	mt. Zim	Smetery 05/	04 DONE L	Andsda	un mot
Baltimore	ermit. epartn nports ny inju		21. Signalure y Funeral Service Lice		22. Nam	and Address of Ficility	nes JR	Funes	ALSVE FA
	20 E a d		23a. Part1. Enter the disease, or cor	end fore	death. Do not dates the	4N BRIAD	WAY BH	Hto. m	d 2/2/3 Approximate
	4/		shock, or heart failure. List onf	one cause on each line.		node or dying, such as cardiac	or respiratory arrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aDue to (or as a co	ROSEPSIS				4 DAY3
	Examiner	,	Sequentially list conditions,	b. ATRI		RIZLATION			UNKNOWN
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,	le be executed ysician and e burial-transit	Exan	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):	ATIZIAL 7	^		
8760	ite be iysicia ne bur	cal		d. ARTER	105CZERO	TIC MEARS	DISE	ASE	٦4
89 x	leath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome of p	regnancy			23d. Date of del	heav
P.O. Box	To the Hospital or Attanding Physician: The law requires that the death certifics within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as it	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown		c pregnancy (specify)		Month	Day Year
٥,	es that igned b be deta	by Pr	Part II. Other significant conditions	4	ot resulting in the underlyi	ng cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ords	w require been sig should b		- HYPERT	ENSION		, , , , , , , , , , , , , , , , , , ,		2 No 3 Pr	obably 4 Donknown
leco	The law rate has be page 2 sh	Completed	- CHRONIC	2 OBSTEN	ニガンミ 21	NG DISEA	32 24a. Was an autopsy	prior to d	itopsy findings available completion of cause of
al F	ician: The certificate rector, pag		W/4/	BETES M	EZZITU-		1 Yes 2 Yes		2 No
Z.	ysicial Is certi directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ ⊀0	Hospital:	2 ER/Outpatient 3	Othor	h (Check only one)	6 □Other /Spe	cifu)
n of	ding Phy h. After thi funeral	n: T	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye			28d. Describe how inj		<b>y</b> /
Sion	Attandir death. ctor: Af y the fu	catlo	2 Accident Investigation 3 Suicide 6 Could not	on .	М	1 ☐ Yes 2 ☐ No			
Division of Vital Records,	tal or Attand rs after death al Director: ed in by the f	Certification:	4 Homicide determine	28e. Place of Injury - building, etc. (S	At home, farm, street, fac pecify)	etory, office	28f. Location (Street a City or Town, Sta		ıral Route Number,
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by:	edical	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exe	hysician: To the best of m miner: On the basis of exa and manner stated.	y knowledge, death occur mination and/or investiga	red at the time, date and place, tion, in my opinion, death occur	and due to the cause red at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier	RODA		29c. License number	29d. D	ate signed (Month	
	17		30. Name and address of person who	200/019	ND.	D 23300		APRIL	29 2005
	5		30. Name and address of person who	completed cause of death	(Item 23a) (Type, Print)	BON SEZU.	BAZTO	171D.	21223
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 3 2005	32. Registrar's	Signature ,	,			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygieneo of

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Physician
/Medical
Examiner

**Funeral** Director

tiled within 72 hours after death with the Maryland permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural; or Items 23a or 28e-f show any highry or other traumatic event. It is Marcical Examitted any once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours atter death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 - State Unpend Item 2 Registrar		II <b>,27,2</b> 8	Cert	incate of	843 <sub>th</sub> 5-5		Reg.	Z U U J No.		4.5	
,	1. Decedent's Name (First, Middle, Last)						2. Date of [		, Day 2005 Year	3. Time of De 2236P.		
i	Raleigh Green			1				1./		22301.	М	
r	4a. Facility Name (If not institution, give s Johns Hopkins Hosp		1		4b. City, Town, or Baltimo1		ath		4c. County of Death			
Ī	5. Social Security Number Unk 6. Sex	7. Ag	ge (In yrs. last bir 35	thday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Day, Үв	nar) Cour		oreign	
	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loca	ation				1	0d. Inside City	Limite	
101	MD			ltim					'	1X Yes 2		
ĕ	10e. Street and Number				10f. Zip Code			10g.	0g. Citizen of What Country?			
<u>=</u>	1428 E. Federal S	treet				21218			USA			
ner	11. Marital Status unk	12. Was Decedent Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (	Specify Yes or N	10-	14. Race - Americ			
by ru	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:			Tes, specify cuba	Specify:	ito rican, etc.)		Specify: bla	_		
G	15. Decedent's Edu	cation	16a.	Decede	ent's Usual Occup	ation	unk	16b	. Kind of Business/Inc	dustry	unk	
Completed by Funeral Director	(Specify only highest grade	College (1-4or	5+)	life. DO	ind of work done o O NOT use retired	during most of wi	orking		<b></b>			
2	17. Father's Name (First, Middle, Last)					18. Mother's Na	ame (First, Midd	le, Maid	den Sumame)			
2	Raleigh Green	ı				N	orma Da	vis				
	19a. Informant's Name/Relationship (Type	pe, Print)	19b	. Mailing	Address (Street	and Number or F	Rural Route Num	ber, Ci	ty or Town, State, Zip	Code)		
	Jeff Koonce/cousin				lain Stre					ŕ		
- 11	20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation 5 XOther (Specify)		20b. Place of cemeter	f Disposi	ition (Name of atory or other plac		Date		. Location - City or To	wn, State		
	21. Signature of Euneral Service License Ronal C		ector	St.	Name and Addres ate Anat	ss of Facility Omy Boar	d 655 W	. В	altimore S	treet		
	1 300 1000 01/	a com		Da.	icimore,	riD 212	.01					
	23a. Part. Enter the disease, y complishoot, or heart failure. List only or immediate Lause (Final disease or condition resulting in death)	Asphyxi Due to (or as	inea .a consequence	of):			ac or respiratory	arrest,		Approximate Interval Betwee Onset and Dea		
	Aspiration of foreign objects  b											
9	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
Examiner	that initiated events											
ĭ	resulting in death) Last	Due to (or as	a consequence	of):								
Medical												
	IF FEMALE:											
completed by ringsicians	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other <i>(specify)</i>	<del>.</del>			23d. Date of delive Month	ry Day Yea	ar	
Ē	Part II. Other significant conditions con	tributing to death t	out not resulting in	n the und	derlying cause give	en in Part I.	23e. Dio	tobaco	o use contribute to the	e cause of deat	th?	
ien n)	Cocaine and narcot	ic intox	ication				1	] Yes	2∭No 3□Prob	ably 4 ∏Unk	nown	
ninpie							per	opsy formed			arlable se of	
	25. Was case referred to medical					76 Place of Do	1 Yes		No 1 Yes	2□ No		
0	examiner?	lospital:	ent 21X ER/Ou	tnatient	3□ DOA Othe	ar.	ath (Check only		6 ☐Other (Specify	()		
٠,	27. Manner of Death	28a. Date of Inju (Month, Da		Time of	28c. Injury Work	4 Littersing				,		
28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?  28d. Dascribe how injury occurred by 1 Natural 5 Pending investigation 1 A-17-05 9:25 p.M. 1 Yes 2 XNo suspected controlled										ags or d dange	TOUS	
3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									and Number or Rura	l Route Number	,	
Cal C	(Check only 2X Medical Examin	sician: To the best ner: On the basis o	f examination and	e, death o	occurred at the timestigation, in my or	ne, date and place	e, and due to th	e cause	, Maryland  e(s) and manner as st and place, and due to	ated. the cause(s)		
Med	one) 29b. Signature and title of certifier	and manner st	ated.		29c. License				Date signed (Month, I			
-	Par all A	N	0	OCME April 18, 2005								
	worsha "H	neu	1 MD	)		T.PIII 10, 2003						
ì	30. Name and address of person the co	mpleted cause of	ath (Item 23a)	(Type, Pr		Penn Str	eet Ra	1+in	nore, Mary	1 and 21	201	
	TUSKU Z (5) 31. Date filed (Month, Day, Year)	B. Registi	ar's Signature	1	224 1	OTHE DOL	cci Da.	LULI	iore, rary.	ranu ZI.	<u> 401</u>	
e ' r	MAY 0 3 2005		, X /	1000								

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 2, 2005 **Physician** Richard Year Graff 6:00 ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2028 Paulett Rd. Dundalk Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** 218-26-8835 1**X**1 M 2□ F 77 Yrs. Director April 6,1928 MD. Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event. Its Medical Evantinar must be retilised at Director MD. Baltimore Dundalk 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2028 Paulett Road 21222 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 XYes 2 No Specify: 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 years Dealer Antiques 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theodore Graff Juanita D. Zang 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Loeffler sister 2237 Barrison Point Road, Essex, MD. 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ott 1 ☐ Burial 2X Cremation 3 ☐ Removal from State May 4,2005 | Baltimore City, MD <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Bayview Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundlak, MD. 21222 23a. Part 1. Enter the disease or complications that caused the death. Donot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final roke Physician disease or condition resulting in death) Week /Medical Due to (or as a consequence of): Examiner reatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. the attending physician Pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? jo Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔀 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: After 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year) 0 D33316

Registrar

State

Blown &

person who completed cause of death (Item 23a) (Type, Print)

Pellantin MO

32. Registrar's agnature

5505 Hipkin Bayner Circle Baltimore MOZIZZY

			For Stete Registrar		Marylan		artment o			/lental Hyg	jiene	05	14936
	Physici		Decedent's Name (First, Middle,     Ruth A. Gray	Last)		-				2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medio Examir			riswal !	tospir		La	usel	tion of Death		Grin	inty of Death	eorge's
	Funeral Director		5. Social Security Number 214–54–7129  Usual Residence of Decedent	7. 1 M 2 <b>X</b> F	Age (In yrs. 84	Yrs.	If Under 1 Y	ear If Un ays Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day 03-08-19	? Year) 921	9. Birthp Coun Maryla	lace (State or Foreign try) nd
	Aarylend f show	or	10a. State 10b. County  MD NA		10c. City	y, Town or Lo	cation					10	0d. Inside City Limits 1 X Yes 2 □ No
	with the hard or 28a-	Director	10e. Street and Number			Dar	10f. Zip Co	ode			l0g. Citizen	of What Coun	
9036	72 hours after deeth with the Marylend natural', or Items 23a or 28a-f show alsal Exacilisat sust be nutified at	by Funeral	103 N. Bentalou Str  11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Decede Armed Force	es? ∑No				c Origin? (Sp xican, Puerto ecify:	ecify Yes or No- Rican, etc.)		SA Race - Americ Black, White, o ecify: Black	etc.
21215-0036	Althin han a	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 7	Education grade completed) College (1-4	or 5+)	(Giva	dent's Usual C kind of work o DO NOT use r	tone duning	most of work	ting	16b. Kind of	Business/Inc	
Maryland 2	is 1 and 2 should be filed world the alth and Mental Hygie Item 27 le marked other to other treumatic event, In	To Be C	17. Father's Name (First, Middle, L. Clarence Adams				18. Mother's Name (First, Middle, Maiden Sumame)  Alice Adams  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
			Julia L. Scovens/ 20a. Method of Disposition		20b. P	2509 W	V. Mosher	Stree	t Balto	al Route Numbe , MD 21216 Date	ò	wn, State, Zip	
Baltimore,	permit. Pages Department of I Importent: If It any Injury or o once.		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Support of Funeral Service Li	ecify)	iter I.	g Memori	natory or other al Park  2. Name and A		04-30	-05 F		stown, M	
	Priysician /Medical Examiner		23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	ny one cause on eac	i iirie.	n. Do not ent	er the mode of	f dying, suc	h as cardiac	N. Gilmor or respiratory arm	est,		MD 21217 Approximate Interval Between Onset and Death
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al Records,		Complet								24a. Was a autops perform	ned?	prior to con death?	osy findings available apletion of cause of
Division of Vital	Attending Physicien: 7 r death. ector: After this certifice by the funeral director, p	Certification; To Be	25. Was case referred to medical examiner?  Yes 2 No  27. Manner of Death  1 Natural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could no	tion		ER/Outpatier 28b. Time of Injury		Othor	Nursing Ho	h <i>Check onl</i> on me 5 ☐ Reside 28d. Describe ho	ence 6 Co ow injury occ	curred	
Divi	e Hospitel or At 24 hours after d e Funerel Direct letely filled in by		4 Homicide determin	ed 289. Place of building,	etc. (Specify	')	eet, factory, of			28f. Location (Si City or Town	n, State)		
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)	o Twiting	~	29b. Signature and title of certifier	Shit	- Di	>	29c. Li	cense numb	5927	7	9d. Date sign	ned ( <i>Month, E</i>	Oay, Year)
	3		30. Name and address of person w	completed cause of	of death (Item	23a) (Type,	Print)	re (	heve	red at the time, d	lary !	and	
	Sta Registr	ite ar	31. Date filed (Month, Day, Year)	2005 33 Aeg	istrar's Signal	ture	ule	,		17			

			1 - For State Registrar	State of M	aryland .		artmen rtificate					giene /	2005	14937
	Physici	an	Decedent's Name (First, Middle, Last	t)							2. Date of Dea Month,	ıth Day	Year	3. Time of Death
	/Medic		Lucille (cin	Hins							Monl	27	2005	4:15 PM
1	Examir	ner	4a. Facility Name (If not institution, give	1	)				Location of	of Death			ounty of Deat arford	
	Francis		5. Social Security Number 6. So	LANE 7. AC	ge (In yrs. last	birthday)	If Under	1 Year	If Under	24 Hrs.	8 Date of Birth			hplace (State or Foreign
	Funeral Director			□M 21 <b>X</b> F	85	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day November	30. 19	ng M€	nuntry) aryland
	P .		Usual Residence of Decedent									,		
	arylar show	_	10a. State 10b. County  MD Harfo:		10c. City, T	own or Lo								10d. Inside City Limits 1 ☐ Yes 2 No
	he M	Director		.·u										
	with t		10e. Street and Number 2727 Greene Lan	0			10f. Zip	21013	ζ				n of What Co	ountry?
	Jeath ms 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13.1				ain? (Spe	cify Yes or No-		Race - Ame	nican Indian
ယ္	or Iter	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑	?	1					cify Yes or No- Rican, etc.)		Black, White	e, etc.
8	72 hours after death with the Maryland neturel', or Items 23a or 28e-1 show Alcal Exart or Inval to Itelified at	l by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1□Yes 2	No ⊠	Specify:			S	pecify:	hite
5-0	within 72 hours after death with the Marylanijene. rthen "neturel", or Items 23a or 28e-f show	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	1	6a. Deced	dent's Usua kind of wor DO NOT us	l Occupa k done d	tion uring mos	t of worki	ng	16b. Kind	of Business/	Industry
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Maryland 21215-0036		To Be	George	Buffin	gton					elaio				lling
Mar			19a. Informant's Name/Relationship (7		1		-				I Route Numbe			Zip Code)
	s 1 and Heal Heal		Lucinda Meyers-d  20a. Method of Disposition	augnter	20b. Place						uin, MD	210	tion · City or	Tourn State
5			1 🗷 Burial 2 ☐ Cremation 3 ☐				sition (Nam natory or ot Cemet		9)	5/4/			s, MD	Town, State
Baltimore,			* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service □	_	1				s of Facilit			-	•	Home, Inc
ä	permit. Departr Importe any inje		MM			10	150 Yo	rk F	₹₫.,	Tows	on, MD	2120		rionic, inc
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause one cause on each li	d the death. [ ine.	Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Sylsis										Davis
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	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events	. Hem	neze à c	10	Shive	2						Tmanh.
o,	be executed siclan and burial-transit		resulting in death) Last  Due to (or as a consequence of):											
8760,	death certificate be executed e attending physiclan and of for use as the burial-transit	Physician/Medical		d										
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Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 poinths?	23c. If yes, outcome 1□Live birth	2 Fetal de	ath 3	Ectopic pre					230	I. Date of deli Month	very Day Year
P.O.	he de / the a	ysic	1 Yes 2 No	4□Pregnant a 9□ Unknown	t time of deatr	n 5∟	Other (spe	ecify)						.,
	law requires that the de as been signed by the 2 should be detached		Part II. Other significant conditions co	ontributing to death b	out not resultin	ng in the u	nderlying ca	iuse give	n in Part I.	-	23e. Did to	bacco use	contribute to	the cause of death?
rds	quires n sigr	d by	Diabetes COPD.	1+170, 7	Jysphi	Link	A50	CUD	,		14	es 2□1	lo 3□Pro	obabiy 4 Unknown
00	aw ree	Completed			, ,		,				24a. Was a		4b. Were au	topsy findings available
R	9 - 9	ШО									autops perfor	med?	prior to death?	completion of cause of
ita	icien: Th certificate rector, pag	Be C	25. Was case referred to medical						26. Place	of Death	Check on or		1 🗆 163	2 140
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ū	ding Ph I. After th tuneral	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry 28 ly Year)	b. Time of Injury		Bc. Injury Work			28d. Describe h	ow injury o	ccurred	
isio	ttend death stor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	One Diese of In			М		es 2□1	-	06 1 10 - 10			
Division of Vital Records,	after Direction by	Certification;	4 ☐ Homicide determined	28e. Place of In building, et	tc. (Specify)	, iam, str	eet, tactory,	опісе		-	City or Town	n, State)	umber or Hu	ral Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a. Certifier 12 Certifying Ph	relation. To the best	of my knowla	dya, Jeati	i occurred a	d this time	a, data and	d place, a	ind das to the c	สนุจซ(จ) สกิ	น์ เกลท์ที่เฮา สร	slated.
	the Ho nin 24 the Fu	ledical	one)	iner: On the basis o and manner st	of examination	and/or in	vestigation,	in my op	inion, deat	th occurre	ed at the time, d	ate and pla	ace, and due	to the cause(s)
	できたのう	Σ	29b. Signature and title of certifier	, ,		ENDY		License					igned (Month	* -
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	(U'			completed cause of c	death (Item 23	Ba) (Type,	Print)	13/40	/	72	han	n	11	1 > 30
	Sta	te	31. Date filed (Month, Day, Year)	32 registr	rar's Signat	,	المان			1201	hmore		· ~ ~	1257
2	Registi	- 1	MAY 0 3 2	005 Bee	مار ري	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Kenneth D. Howard Sr. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Kenneth D Howard 2005 1043A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES BALTIMORE HOSPITAL Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Months Hours Min 1 **3** M 2 □ F Yrs. Director 218-70-0363 47 Aug 21, 1957 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 Is marked other than "natural", or Itams 23s or 28s-1 show traumatic event, If a McJICL Eventhar in at Inust be notified at 1 Yes 2 □ No Director Maryland Baltimore Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7334 Roosevelt Boulevard 21075 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hersey Ice Cream Company Supervisor 12 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygin mportant: If them 27 is marked any injury or other to once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roland Howard Lillie Howard 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7334 Roosevelt Boulevard Elkridge, Maryland 21075 Kenneth Howard Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) 04/29/05 Elkridge, Md. Meadowridge Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service 1600 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** poglycemia disease or condition resulting in death) hour /Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): 68760 certificate be Physician/Medical use as Box IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Day 4☐Pregnant at time of death 5 Other (specify) detached o the 9 Unknown the Š ۵ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, requires 5than rema 1 ☐ Yes 2 ☐ No 3 Probably 40 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼ No cate has autopsy performed? Yes 2 No certificate 2 X No 1 ☐ Yes Vital Attending Physician: After this certification, 25. Was case referred to medical examiner?
1 LYes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 Proutpatient 3□ DOA Division of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident Director 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by hours after 4 Homicide determined Hospital or within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) D0061564 Aton Ave, BAI Honore, MO 21229 30. Name erson who completed cause of death 31. Date filed (Month, Day, ear) 32. Registrar's Signature State

ORIGINAL

- DHMH 17 Rev 1/2001

Registrar

2005

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State of Maryland / Department of Health and Mental Hygien® Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 29, Day 2005 Yeer **Physician** Sigfried G. Hatlem 3:45 р м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Harford Bel Air Jacobs Well Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 11, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1914 Days Hours Min 1 🗌 M Norway Yrs 90 Director 099-24-5684 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Itams 23a or 28a-f show traumatic avent, the Medical Examiner must be notified at Bel Air 1 Yes 2 No Harford Md. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21015 522 Thomas Run Road U.S.A. death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 2 should be filled within 72 hours after n and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) family care nanny 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Sumame) Be Sophie Davidsen Christofer B. Hatlem 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Peges 1 end 2 s. ment of Health an lant: if itam 27 is r 125 Versailles Circle, Towson, Md. 21204 Nina Messoris/niece other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Peges Department of I Important: If its any injury or o 1 Dunial 2 ☐ Cremation 3 ☐ Removal from State 5/3/05 Bel Air, Md. Bel Air Mem. Gdns. \*4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee 21014 610 W. MacPhail Road, Bel Air, Md. Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Į in the past 12 months? Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes detached 9 Unknown 9 Unknow been signed by ant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 90 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an certificate has page 2 autopsy perfor 1 Yes assiste Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes No Certification: To IVIA 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospitel or Attanding Injury Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title 29d Date signed (Month, Day, Year) 30. Name and address of person who comn ed cause of eath (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

			1 - For State (	of Maryland / Dep <i>Ce</i>	artment of Health		lygiene   5	14940
	Physici	an	Decedent's Name (First, Middle, Last)	11. 77 11		2. Date of Month		3. Time of Death
	/Medic	al	Richard Phi  4a. Facility Name (If not institution, give street and no		1. Ch. T.	May 1	L, 2005	3:03 a. M
	Examin	ier			4b. City, Town, or Location		4c. County of	
	Funeral		Annapolis and Manoff Roa  5. Social Security Number 6. Sex	7. Age (In yrs. last birthday			Birth 9 Day, Year)	ore County  Birthplace (State or Foreign Country)
	Director		168-66-0473 IMM 2□F Usual Residence of Decedent	32 Yrs.	Months Days Hours	s Min. (Month, APR 1		ennsylvania
	/land		10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	a-fsh	ctor	Maryland Baltimore		Baltimo	ore		1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of Wha	at Country?
	s 23a		4069 McDowell Lane	4.5	21227		USA	
(0	r Item	Funeral	Amed F	cedent Ever in U.S. 13. orces?	Was Decedent of Hispanic Olf Yes, specify Cuban, Mexic	Origin? (Specify Yes or can, Puerto Rican, etc.)	No- 14. Race - Black,	American Indian, White, etc.
03	d within 72 hours after death with the Maryland jene. r than "natural", or items 23a or 28a-f show the Medical Evaluation in the Indiffied at	by	3 ☐ Widowed 4 ☑ Divorced If Yes, G	ive 11	1 ☐ Yes 2 ☐ No Speci	ify:	Specify:	White
5-0		Completed	15. Decedent's Education (Specify only highest grade completed	) (Give	edent's Usual Occupation a kind of work done during m	ost of working	16b. Kind of Busin	ness/Industry
12	within ene. than "	dmo	Elementary/Secondary (0-12) College	(1-4or 5+)	DO NOT use retired)		Restau	rant
d 2	E T E	BeC	17. Father's Name (First, Middle, Last)			ther's Name (First, Mide		Lant
ylar	<b>₽</b> ₩ ₩ ₩	To E	Phillip A. Hall			Jean Loui	ise Staub	
Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic ance.		19a. Informant's Name/Relationship (Type, Print) Phillip A. Hall/Father		ing Address (Street and Num			ate, Zip Code)
			20a. Method of Disposition	20b. Place of Dispo	O Salem Road osition (Name of	York, PA	L /404 20c. Location - Cit	or Town State
E C			1 ☐ Burial 2 X Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State cemetery, cre	matory or other place) ematory, Inc.	5/2/05		
Baltimore,	permit. Departmimporta		21. Signature of Funeral Service Licensee	2	2 Name and Address of Fac	cility	Baltimo	
8	90 1 2 2		Edward A Gregorchi	k	Cremation Soc 299 Frederic	k Road Balt	imore, MD	21228
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	each line.	*	as cardiac or respirator	y arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	(ITIPLE 14)	juvies		·	Oriset and Death
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	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C.					
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0	the dea y the a ached fo	Physician/M	1  Yes 2 No 4 Preg 9  Unknown 9 Unkn	nant at time of death 5	Other (specify)		- Month	Day Year
Δ.	that ed b deta		Part II. Other significant conditions contributing to c	death but not resulting in the u	inderlying cause given in Par	rt I. 23e. Di	id tobacco use contribu	te to the cause of death?
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eco	aw as b	Completed				24a. W		e autopsy findings available
E E	Th ate pag	Con					informed? dea	r to completion of cause of h? Yes 2 \sum No
Zi:	sician: Th certificate irector, pag	Be o	25. Was case referred to medical examiner?  1. XYes 2. No. Hospital:		Other	ice of Death (Check onl		
of	Phy r this ral d	. To	27. Manner of Death 28a. Date	Inpatient 2 ☐ ER/Outpatier of Injury 28b. Time o		Nursing Home 5 Re	esidence 6 XOther (	Specify) At scene
ion	Attending F r death. ector: After by the funer	atlo	1 □Natural 5 □ Pending 2 Accident investigation 5	ntr. Day Year) Injury	Work?		isvolved is u	wher Vilicia Crash
Division	or Atterdented in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Plac build	e of Injury - At home, farm, sti ling, etc. (Specify) 1.	reet, factory, office	28f Location	(Street and Number of Town, State)	r Rural Route Number
Ω	pital c			stree	(	Manett	Road, Balt	imore (M)
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Examiner: On the b	e best of my knowledge, deat pasis of examination and/or in oner stated.	h occurred at the time, date a vestigation, in my opinion, de	and place, and due to the eath occurred at the tim	ne cause(s) and manne e, date and place, and	r as stated. due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	0.0	29c. License number	r	29d. Date signed (N	fonth, Day, Year)
)	7		· Califulla	the	OCME		May 1, 2	005
_	10		30. Name and address of person who completed cau	se of death (Item 23a) (Type,	Print) 111 Penn St	reet Balti	imore, Mary	land 21201
	Sta Registr	1.	31. Date filed (Month, Day, Year) 32 MAY 0 3 2005	Registrar's Signature	ale			

Saint Joseph Medical Center   4b. City, Town, or Location of Death Towson   4c. City   Town, or Location of Death Towson   4c. City   Town, or Location of Death Towson   4c. City   Town, or Location of Death Towson   4c. City   Town, or Location of Death Towson   4c. City   Town, or Location of Death Towson   4c. City   Town, or Location   4c. City   4c. City   4c. City   4c. City   4c. City   4c.	005 14941
4a. Facility Name (If not institution, give street and number)  Saint Joseph Medical Center  4b. City, Town, or Location of Death Towson  4c.  4c.  Towson  4c.  4c.  Towson  4c.  4c.  4c.  4c.  4c.  4c.  4c.  4c	3. Time of Death
Funeral Director  5. Social Security Number  6. Sex  1 M 2 F  7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday)  1 M 2 F  7. Age (In yrs. last birthday)  1 M 2 F  1 M 2 F  1 M 2 F  1 M 2 F  1 M 2 F  1 M 2 F  1 M 2 F  1 M 2 F  1 M 2 F  1 M 2 F  1 M 3 M 3 M 3 M 4 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M 1	28,2005 8:42P M
Director  Direct	County of Death Baltimore
To a. State 10b. County 10c. City, Town or Location Parkville 10e. Street and Number 10f. Zip Code 10g. Citi 7824 Aiken Ave. 21334  11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 15. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	9. Birthplace (State or Foreign Country)  MARYLAND
10e. Street and Number  10f. Zip Code  10g. Citi  11g. Marital Status  11g. Mas Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Marital Status  11g. Never Married  11g. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	10d. Inside City Limits 1 ☐ Yes 2 No
11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 Never Married 2 Married  1 Never Mar	izen of What Country?
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done) during most of working (Give kind of work done) during most of working	14. Race - American Indian, Black, White, etc.
life DO NOT use retired)	ind of Business/Industry
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden)	Himore City
17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Katherine Name)  19. Informant's Name/Relationship (Type, Print)  19. Mailing Address (Street and Number or Rural Route Number, City on the Color of the Colo	niller
19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City on the place)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City on the place)  20c. Lo  20c. Lo  20d. Method of Disposition  1 Date  20c. Lo	r Town, State, Zip Code)
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Lo	ocation - City or Town, State
20a. Method of Disposition  1 Dispos	nonium MD
EVANTEDIA CHAPELXKY HAD	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Interesting in death)  Medical Infrarction  ACUTE MYOCARDIAL INFARCTION  Due to (or as a consequence of):	1 WEEK
Examiner ATHEROSCLEROTIC CORONARY ARTERY DISE	ASE YEARS
if any leading to immediate Due to (or as a consequence of):	
that initiated events c.  Due to (or as a consequence of):	
dical E	
1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
v s 50 a 50 a 50 a 50 a 50 a 50 a 50 a 50	se contribute to the cause of death?
24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1X Yes 2 \sum No
25. Was case referred to medical examiner?	
1 Support of Dooth 1 Support of Dooth 200 Date o	
To be a pool of the pool of th	y occurred
27. Manner of Death 1 Natural 2   Accident   2   Accident   2   Accident   3   Suicide   4   Hom	y occurred
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)	d Number or Rural Route Number,
and manner stated.  29b. Signature and title of cartiler  APP MD Pathologist 29c. License number 29d. Data 4543	d Number or Rural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	d Number or Rural Route Number,
STEVEN R. AXE. M. D. 76Ø1 OSLER DRIVE TOWSON, MARYLAND  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	d Number or Rural Route Number,  and manner as stated. place, and due to the cause(s) e signed (Month, Day, Year)
Registrar MAY 0 3 2005 Keen & Jacks	and manner as stated. place, and due to the cause(s) e signed (Month, Day, Year)

			For State	State of Maryland	d / Depa		lealth and M	lental Hygi	ene 2005	5 14942
			Registrar		- 001	incate of	Dealli		g. No.	1 10 1 60
,	Physici /Medic	al	Decedent's Name (First, Middle, Last)     LELA BERNICE HIL      4a. Facility Name (If not institution, give seems)	GEMAN		Ab City Town	or Location of Death	2. Date of Death Month APRIL	Day Year 27 2005 4c. County of Dea	
	Examir	er				46. City, Town, o	or Location of Death		4c. County of Dea	tn
			MASONIC HOME OF			COCKEY If Under 1 Year	SVILLE If Under 24 Hrs.	0 D-1- ( D)-1-	BALTIMO	
ı	Funeral Director			7. Age (In yrs. I	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 11-25-19		thplace (State or Foreign buntry)
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	he Maryl 28a-f eho	ector	Maryland Baltimore			timore C	ounty			1 ☐ Yes 2 🖾 No
	3a or	ī	300 International	Circle		10f. Zip Code	230	10	g. Citizen of What Co USA	ountry?
	Je 2	era		12. Was Decedent Ever in U.	S. 13. V			ecify Yes or No-	14. Race - Amo	erican Indian.
036	is 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene. Item 27 ie merked other than "natural", or iteme 23a or 28a-f ehow other traumatic event, the Medical Evant at must be notified at	Completed by Funeral Director	1 Never Married 2 Married  ★☑ Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		fYes, specify Cuba 1 ☐ Yes X2X No	dispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi Specify: Wh	e, etc.
5-0	72 ho	eted	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Deced	dent's Usual Occup	oation during most of worki d)	na 1	6b. Kind of Business	/Industry
121	within ine. ihan "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	Unkr	DO NOT use retired	d)	9	Black & D	lookom
2	lled /	ပိ	12 yrs.	N/A			18. Mother's Name	/Eint Middle M		ecker
Maryland 21215-0036	ould be f Mental I varked of	To Be	Unknown				Addie	L. Birdw	ell	
Mar	alth and 27 io m		19a. Informant's Name/Relationship (Ty Norma Ayres (Niece						City or Town, State, . Lair ,Md.	
ē,	item item		20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of matory or other place		1	Oc. Location - City or	
Baltimore,	permit. Pages Department of I Important: If Ite eny injury or or once.		1 Bunal 2 Cremation 3 R '4 Donation 5 Other (Specify)	Me-	tro Cr	ematory	4~29-		Baltimore,	
Bal	permit. Departr Importa eny inju		21. Signature of Funeral Service License . 3.	re, Md. 21	236					
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that coused the death ne cause on each line.	. Do not ent	er the mode of dyir	tion.	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Examiner	ь	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ		· Vasa	ulan DI	Seare		
	ate be executed hysician and he burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
68760,	cate be physicials the bur	cai	L,	1						
P.O. Box (	The law requires that the death certifical site has been signed by the attending phy sage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	3c. If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	y	· · · · · · · · · · · · · · · · · · ·	23d. Date of de Month	ivery Day Year
	s that ined b	y PI	Part II. Other significent conditions cor	ntributing to death but not resu	Iting in the u	nderlying cause giv	ven in Part I,	23e. Did toba	icco use contribute to	the cause of death?
ord	w require been sig should b	ted	Hyporlassi, C	oronoy ar	tey,	) (Sease	-,	1 ☐ Yes	2 □ No 3 □ P	obably 4 Unknown
Records,	yelcian: The law r is certilicate has be director, page 2 sh	Completed by	- Hypo typoul	in ost	es po	resis		24a. Was an autopsy perform	prior to	Itopsy findings available completion of cause of 2 No
Vital		a l	25. Was case referred to medical				26. Place of Death			2)25-140
>	Phyeician: this certific ral director,	To B	examiner?	fospital: 1   Inpatient 2   1	ER/Outpatien	it 3□ DOA Oth			ice 6 Other (Spe	cihi)
ō	Physer this eral dir		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injur	y at	28d. Describe hov		City)
o	After a fund	I I	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wor	rk?  Yes 2∐No			
Division of	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	e Hospita 24 hours e Funera letely fille	Medical C	29a. Certifier 1 Certifying Physical Check only 2 Medical Exemination	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death tion and/or in	n occurred at the tir vestigation, in my o	me, date and place, a opinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as e and place, and due	s stated. to the cause(s)
	orthin Forthin Sompl	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Mont	h, Day, Year)
			P.t. Elast	S. MO.		D	31464		4/28/0	5
	ix		30. Name and address of person who co		23а) (Туре,		Read	10.0	7/20/	-
	Sta	te	31. Date filed (Month, Day, Year)	32. Rigistrar's Signal	ture	localis	Balto.	) year	~100 Y	
	Regist	-	MAY 0.3.2	105 Elegan .	15 19	1	•			

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day: MARTHR IL 2005 3:15 PM Charles Kenneth Holmes, Sr. /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death imore 4b. City, Town, or Location of Death Examiner Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, April 12, Birthplace (State or Foreign Country)
 Maryland **Funeral** Days 1 🔀 M 2 🗆 F 212-14-1286 84 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.

ant of Heatth and Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Madical Executars: sist by notified at 10d. Inside City Limits MD Director Baltimore Glen Arm 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6128 Hutschenreuter La 21057 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1√ Yes 2 □ No WW II If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify: White 3 □Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Brewery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Holmes ပ Henry Ethel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jo Ann Holmes Kirby-daughter 6128 Hutschenreuter La., Glen Arm, MD 21057 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ŏ 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Importent: if any injury or once. \* 4 □ Donation 5 □ Other (Specify) Dulaney Valley Mem'l Gard 5/3/05 Timonium, MD 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MULTISYSTEM FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): DISSEMINATED **Examiner** INTRAVASCULAR COAGULOPATHY 2 DAYS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit RESPIRATORY FAILURE WEEKS the attending physicien and Due to (or as a consequence of): INTERSTIAL LUNG DISEASE WEEKS Physician/Medical use as IF FFMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 XVO 1 Tyes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1V1 Yes 2 1 No certificate has autopsy performed? Yes 2 🗆 No 2 No Yes Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ✓ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) filled in by the funeral Manner of Death 28b. Time of Alter 28d. Describe how injury occurred atural 5 Pending Accident investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and we of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 34543 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, STEVEN R. AXE, M.D. MARYLAND 21204 31. Date liled (Month, Day, Year) 2. Jegistrar's Signatus State MAY 0 3 2005 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

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J.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Charles D. Hetrick April 2005 10:05/4 27 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ivy Hall Nursing Center Middle River

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 95 Yrs. Nov.1,1909 172-01-9913 Director PA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Iteme 23e or 28e-f eho The Medical Exacting must be notified at 1 ☐ Yes 2 ▼ No MD Baltimore Middle River Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1320 Windlass Drive 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify SpecifWhite δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MArtins Tool Maker 8th other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Daniel Hetrick Alice Ebbey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Woodrow /wife 1320 Windlass Drive Baltimore MD permit. Pages 1 an Department of Healt Important: If item 2 any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State DulaneyValley 4/30/05 Baltimore MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221 Approximate Interval Between Onset and Death Pert1. Enter the disease, or coshock, or heart failure. List or comp ns that ceused the death, enter the mode of dying, such as cardiac or respiratory Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner SCULAR ACCIDENT the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetel de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ binknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 2 1 🗌 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) of Death 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred Matural Injury 5 Pending М 1 □ Yes 2 □ No investigation Accident within 24 hours after death To the Funerel Director: , completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) no completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

**ORIGINAL** 

			State of Maryland / Department of		•	-	14947
			1 - State Registrar Certificate  1. Decedent's Name (First, Middle, Last)		Reg 2. Date of Death	3. No.	2 Time of Death
П	Physici	an			Month 2 0	Day Year	3. Time of Death
	/Medic		Edward Michael Hallahan  4a. Facility Name (If not institution, give street and number)  4b. City, Tov	en or Landing of Doub	April 50,	4c. County of Dea	09,00 AM
	Examin	er	004 71 111 71	wn, or Location of Death			
	Funeral		984 Phillips Place  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y	Air 'ear   If Under 24 Hrs.	8. Date of Birth	Harford	
	Funeral Director			ays Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Foreign buntry) INSYLVania
	D		Usual Residence of Decedent		Mar. 18,	1923 161	uisyivaiita
	uylar ihow	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	89-f s	9	Maryland Harford Bel Air				1 ☐ Yes 2 ☑ No
	vith th	Dire	10e. Street and Number 10f. Zip Co		10	g. Citizen of What Co	ountry?
	s 23e	rai		1014		USA	
	er de Itam Der D	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ☑ Married  1 □ Yes 2 ☑ Married	t of Hispanic Origin? (Spec Cuban, Mexican, Puerto F	offy Yes or No- lican, etc.)	14. Race - Ame Black, Whit	
39	urs af	by Funeral Director	3 Widowed 4 Divorced Year or Dates:	No Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show ta Medical Exercit at rotal be rotalised at	ted	15. Decedent's Education 16a, Decedent's Usual O		10	5b. Kind of Business	/Industry
215	hin 7.	pie	(Specify only highest grade completed) (Give kind of work dife. DO NOT use n	lone during most of workin etired)	9 E	altimore	County
2	ad wit	Completed	3 Manager		F	arks & Re	creation
2	oe file	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
Maryland	Ment Ment arkac	2	Michael Joseph Hallahan	Mary E.	lizabeth	Hoban	
a	2 shd and is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (St	treet and Number or Rural	Route Number,	City or Town, State, J	Zip Code)
	l and lealth im 27 im 27 her ti		Mary Hallahan / Wife 984 Phillip 20a. Method of Disposition (Name of Dis	os Plaçe, Be			
0	ges If of h or ot		1 Rurial 2 X remation 3 Removal from State   cometery, crematory or other	r place)		oc. Location - City or	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, It a Medical Exacting trained by ODGe.		*4 □ Donation 5 □ Other (Specify) Hilltop Service  21. Signatur of Fun 1 Service License 22. Name and A	<del>-</del> - + -		owson, Ma	ryland
Ba	permi Depa Impo any i		McComas	ddress of Facility Funeral Hor	me, P.A.		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of	kesbury Road	l, Abing	don, Mary	land 21009 Approximate
			shock, or heart failure. List only one cause on each line.		respiratory arres	00	Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	10052			1245
	Examiner		Due to (or as a consequence of):				
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	uted d ansit	Examiner	cause. Enter Underlying Cause Disease or injury that initiated events c				
ó	exec an an rial-tr	Exa	resulting in death) Last Due to (or as a consequence of):				
8760,	Attending Physician: The law requires that the death certificate be executed rideath. ector: After this certificate hes been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	icai	d				
9	artifica ing ph e as t	Med	IF FEMALE:				
Вох	ath ce ttend or use	an/	23b. Was decedent pregnant In the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregn	ancy		23d. Date of del	ive <i>r</i> y Day Year
0	the a	sic	1 Yes 2 No 4 Pregnant at time of death 5 Other (specifing 9 Unknown	(y)		HOU	Day
α.	es that the death cer igned by the attendir be detached for use	by Physiclan/Med	Part II. Other significent conditions contributing to death but not resulting in the underlying cause	e diven in Part I	23e Did toba	cco use contribute to	the cause of death?
Records,	signe d be		the state of the s	o given in take.			obably 4 Unknown
20	w requir been si should I	Completed			:		
Re	he taw hes ge 2 s	dm			24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
	ician: Th certificate rector, pag	e Co	25. Was case referred to medical	26. Place of Death		ZNo 1 ☐ Yes	2 No
Division of Vital	ysicie s cert direct	To B	examiner?  1  Yes 2 No	Other: 4 Nursing Hom		ce 6 □Other /Sna	nihr)
0	g Physicar this neral di	n; T	27. Manner of Death 28a. Date of Injury 28b. Time of 28c.		3d. Describe how		ony)
0	ath. or: After ne funer	atio	2 Accident investigation	1 Yes 2 No			
<u> </u>	l or Atte after de Directo	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, off building, etc. (Specify)	fice 28	3f. Location (Stre	et and Number or Ru State)	ıral Route Number,
Ω	rrs aff	Cer					
	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funaral Director: After this certificate he completely filled in by the funeral director, page	edicai	29a. Certifier  (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in a	he time, date and place, ar my opinion, death occurred	nd due to the cau d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the vithin 2 To tha complet	Med	and manner stated.	cense number		I. Date signed (Monti	
	- 3 - 0		M 1266 m	2114		1. 2 2.	, say, roar,
	20		30. Name and address of person who completed cause of plath (Item 23a) (Type, Print)	117		104 L, LOC	,
	. 7		Farker MP leasons Northern Ches	Sexulle the	ice =	KTon m	0
	Sta	te	31. Date filed (Month, Day, Year) MAY 0 3 2005  32. Redistrar's Signature	1 11-11	7		
	Registr	ar	MAT U 3 ZUUU DECENES DE PARTE				

**Physician** /Medical **Examiner** 

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Director:

within 24 hours To the Funeral

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permit. Pages 1 and 2 Department of Health a Importent: if Item 27 le any injury or othar tret once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

items 23a or 28a-f ehow Examinar must be notified at

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d 2 should be filed with and Mental Hygier 7 ie marked othar th

The Medical

Directo

Funeral

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The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

page 2 should be director, funeral filled in by

Completed by Physician/Medical Be

Medical

State Registrar

Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown 25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No 27. Manner of Death 1 Natural

2 Accident

3 Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending investigation 6 Could not be determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number D 26191

1 ☐ Yes 2 ☐ No

1 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) April 29, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Anusha Sirithara, Suite 10, 2112 Belair Road, Fallston, Md21047

31. Date filed (Month, Day, Year)

MAY 0 3 2005

DHMH 17 Rev 1/2001

the Medical Examiner must be notified at Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 ☐ Married ŏ 1 ☐ Yes 2X No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fit.
Department of Health and Mental by
Important: If item 27 is marked oth
any injury or other treumatic event
<u>once.</u> Be 2 (SOCIAL 19b Walling Address (Street and Number of Bural Route Number City or Town, State, Zip Code)
827 Linden Avenue Baltimore, MD 21202 WORKER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ♥ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 ₩ Other (Speech) in state MT.CARMEL 6/06/2005 21. Signature of Funeral Servi Licensee Ronald S. Wade, Direct <del>Baltimore, MD</del> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician disease or condition resulting in death) erdiamyop it hy /Medical Due to (or as a consequence of): **Examiner** wasestive Hourt Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of. The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last erchie vesular Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, c C Physician/Medical Circhosis IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed To the Hospitei or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) examiner 1X Yes Hospital: 1 ☐ Inpatient 2 No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) After th funeral Manner of Death 28c. Injury at Work? 8b. Time of Certification: 1 Natural 2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No investigation hours after death. within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accurred at the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

7. Age (In yrs last birthday,

10c. City, Town or Location

Baltimore

10f. Zip Code

47

Days

21201

1. Decedent's Name (First, Middle, Last)

Arnold Johnson

5. Social Security Number

217-68-0320

10e. Street and Number

10a. State

MD

Director

Usual Residence of Decedent

4a. Facility Name, (If not institution, give street and number)

10b. County

501 W. Franklin Street

N/A

1 X M 2 □ F

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State State Registrar AMEND ITEM #10a,b,&g,19a&b,20adillogic PER 6844 6/02/05 JFFeg. No. 2. Date of Death Month 4b. City, Town, or Location of Death 4c. County of Death Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 13, 19 Birthplace (State or Foreign Country) Hours 10d. Inside City Limits 1**X** Yes 2 ☐ No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: black unk 16b. Kind of Business/Industry unk unk 18. Mother's Name (First, Middle, Maiden Sumame) unk 20c. Location - City or Town, State DUNDALK, md. 22. Name and Address of Facility DOSEPH L. RUSS, FUNERAL HOME, P.A. 2222 W.NORTH AVE. BALTO, MD Appreximate Internal 2 to en Unless and Chown 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Yunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

DHMH 17 Rev 1/2001

State Registrar 31. Date Med (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print) Royal Ave. Balto.

D0059056

D. Salaja MO

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SR. Q Month 20°CS 5:35 AM R. Janes lhomas 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Gon Burnia 4c. County of Death Anne Arunda North arundel Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 08 · 26 · 1936 1 MM 2□ F 217.32.1174 68 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No NIA MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code STREET 223 M. EDGEWOOD 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 YRS TRANSPORTATION MTA DRIVER PASTOR IRAH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES E. JONES V. BUTCHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA JONES ST., BALTO. MO 223 N. EDGEWOOD WIFE 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ARBUTUS 05.05.05 BALTO, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re of Funeral Service Licenses 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Septic Immediate Cause (Final disease or condition resulting in death) Shock week Due to (or as a consequence of): 201513 Candida and stage vend directe (on dialysis) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify)

3 Probably 4 □Unknown

24b. Were autopsy findings available prior to completion of cause of death? 2 No

1 Yes

29d. Date signed (Month, Day, Year)

**Physician** /Medical Examiner

burial-transit

page 2 should

after death.

within 24 hours a

To the Funeral C

completely filled i

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29b. Signature and ite of certifier

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or Attending Physician: The law requires that the death certificata be executed

P.0.

Division of Vital Records,

**Physician** 

Examiner

10a. State

Director

Completed by Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturef", or items 23e or 28a-f show any njury or other treumatic event, the Medical Eventinal must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Failure; Lewer cardiomyopathy heart 1 ☐ Yes 2 ☑ No acute respiratory 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1- Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

1

30. Name and address of person who empleted cause of death (Item 23a) (Type, Print) STUNET JACOBS MB 305 Pospital Dr. Glen Burnie, MB 32. Registrar's Signature

29c. License number

00022483

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				1 - For State Registrar	State of M	aryland / Dep			vientai Hygie	enen n 5	14951
	_					CE	ertificate of	Death		ı. No.	14701
		Physic	ian	Decedent's Name (First, Middle, L.	ast)				2. Date of Death	Day Year	3. Time of Death
		/Medi		Kolle	2 D.	Jones	.2		April	30 2005	10:357. M
•		Exami		4a. Fecility Name (If not institution, g	ive street and number)		4b. City, Town,	or Location of Death		4c. County of Dear	th ,
				HARFORN ME	MORIAL H	OSPITAL	Havre	de Gras	ce	Harton	d
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		P .		Usual Residence of Decedent		T					
		how in it	_	10a. State 10b. County		10c. City, Town or I	1				10d. Inside City Limits
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		dea dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of	Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	
	9	after or he	교	1 Never Married 2 Married	1 M Yes 2 I If Yes, Give Year or Dates:	No	1 ☐ Yes 2 No		rican, etc.)	Black, Whit	e, etc.
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23	21	E	ğ	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retire	during most of work ed)	ang .	$\wedge$	
3	7	be filed within 72 hours after lal Hygiene. d other then "natural", or Ite event, the Medical Examine	Completed by Funeral	12		late	J OF ED	altimor	e (	ommuni	cations.
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0	2	Should h		19a. Informant's Name/Relationship		19b. Mai	ling Address (Street		ral Route Number, C	City or Town, State, 2	Tip Code) 21078.
4 30 05	Ž	and 2 selth e n 27 ie		Pattie Inne	Five- 20	0 142	RIMMS	show A	1 11	e de Gra	ca 110
3	<u> 5</u>	T Her Itam othe		20a. Method of Disposition		20b. Place of Disp	position (Name of	300191		c. Location - City or	Town, State
+	٤	Peges nent of int: if It iry or o		1 Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spec		10.	ematory or other pla	L 5	10= 0	10. 2.	- mn
•	Baltimore, Maryland 21215-0036			21. Signature of Funeral Service Lice		GlenHaver	22. Name and Addre	ess of Facility			re MD.
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				23a Part I Enter the disease of ca	malications that cause	d the death. Do not or	IAUS FUN	ERHC (H4)	PEC. 0800	HARFORG	Approximate
				23a. Part1. Enter the disease, or co shock, or heart failure. List on	y one cause on each li	ine			or respiratory arrest		Interval Between Onset and Death
N.	1	Physician		Immediate Cause (Final disease or condition resulting in death)	a MOTHY	TIL LUMG	Omuru				
0		/Medical Examiner		resulting in death)		a consequence of):					
十二		- Addition	_	Sequentially list conditions,	0.	erun f					
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7	ta	ilcien: Th certificate rector, pag	Bec	25. Was case referred to medical	T			26. Place of Deat	h (Check only one)	/ 10 16s	2 10
O	<u> </u>	ysicien: The is certificate hu director, page	ToB	examiner7	Hospital:	ent 2 ER/Outpatie	ent 3 DOA Ott	hoe	me 5 Residence	e 6 DOther (Spec	achmithin
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8	<u>.</u>	ndin ath. r: Aft	atio	1 <sup>¶</sup> Natural 5 Pending 2 Accident investigati		y Year) Injury		Yes 2 □ No			
_	Division of Vital Records,	Atte	2	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	4   200. Flace of Inj	ury - At home, farm, si c. (Specify)	treet, factory, office		28f. Location (Stree	et and Number or Ru	ral Route Number,
Rolla	Ö	ei or s effe si Dir	Certification;	4 Tiomicide	Sullding, et	с. (Зр <del>о</del> спу)			City or Town, S	siate)	
-		hour hour mere y fille		29a. Certifier 1 Certifying F	hysician: To the best	of my knowledge, dea	th occurred at the til	me, date and place,	and due to the caus	se(s) and manner as	stated.
		To the Hospitel or Attending Physwithin 24 hours effer death. To the Funerel Director; After this completely filled in by the funerel di	Medical	(Check only 2 Medical Exe	eminer: On the basis of and manner sta	t examination and/or ii	nvestigation, in my o	opinion, death occurr	red at the time, date	and place, and due	to the cause(s)
		Withi To t	Σ	29b. Signature and title of certifier			29c. Licens	se number	29d.	. Date signed (Month	Day, Year)
				M1 449 51	m mo	e <sub>k</sub>	104	8412		5/1/0)	
		(X)		30 Name and address of person who	completed cause of d	leath (Item 23a) (Type	, Print)	1	1100	4.10	34/
		5		MI SVT GIN	1 70	5. U	MICH /	MA	1706 N	nd a	078
		Sta		31. Date filed (Montt), Day, Year)		ar's Signature	1				
		Registi	rar	MAY 0 3	2005	me K L	2000				

		•	State of Maryland / Department of Health and  State Registrar  State Certificate of Death		giene 05	14952
	Physici /Medic		Decedent's Name (First, Middle, Last)     FRANCIS MICHAEL KAUFMAN	2. Date of De		Year 3. Time of Death 05 3.25 P M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deat  4c. City, Town, or Lo	8. Date of Bir	ay, Year)	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	8–28–	1926	MARYLAND
	death with the Maryland rms 23a or 28a-f show rmust be notified at	tor	10a. State 10b. County 10c. City, Town or Location ROSEDALE			10d. Inside City Limits 1 Tyes 2 No
	s or 28	I Director	10e. Street and Number 10f. Zip Code 21237		10g. Citizen of Wh	
936	72 hours after death natural", or Items 2 dical Examenar mus	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Note of this panic Origin? (5 If Yes, specify Cuban, Mexican, Puel 1 Yes, Sive Year or Dates: 1945–46	Specify Yes or No rto Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. White
ANC 1	within ene. than "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  15a. Decedent's Usual Occupation (Give kind of work done during most of w	orking	16b. Kind of Bus	iness/Industry
land	uld be filed fental Hygli rked other	To Be C	17. Father's Name (First, Middle, Last)  JAMES  KAUFMAN  18. Mother's Na  AGNES	me (First, Middle (SCHA	a, Maiden Sumame .P)	)
∩, Mary	d 2 should be the and Mental I the and Mental I to marked or traumatic events		19a. Informant's Name/Relationship (Type, Print)  JOSEPH KAUFMAN/ SON  19b. Mailing Address (Street and Number or R 2925 EDGEWOOD AVENUE		oer, City or Town, S	tate, Zip Code) 21234
MQ//	Pages 1 and 2 should nent of Health and Men int: if Item 27 Is marke iry or other traumatic		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  1 SeBurial 2 □ Cremation 3 □ Removal from State	Date	20c. Location - C	City or Town, State
Saltimor	permit. Page Department o Important: If any injury or once.		1 Donation 5 □Other (Specify) Holly Hill Memorial 5 □ 3  21. Signature of Funeral Service Licensee 22. Name and Address of Facility C	VACH 'ROS	EDALE FUN	
150 P	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or at a consequence of):		DALE, MD arrest,	Approximate Interval Between Onset and Death
8760,	tte be executed lysicien and ne burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):			
P.O. Box 6	the attending the for use as	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date Mon	of delivery th Day Year
	uires that the signed by id be detac	by P	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.			bute to the cause of death?
Division of Vital Records,	The law requii ate has been s page 2 should	Completed		24a. Wha: auto perf 1 □ Yes	opsy proformed? de	fere autopsy findings available ior to completion of cause of sath?
Vita	ician: Th certificate rector, pag	Be	examiner?	eath (Check only		
ion of	To the Hospital or Attending Physician: The lawinin 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	atlon: To	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation   Pending investi		sidence 6 Othe how injury occurre	
Divis	al or Atte s after de el Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Numbe own, State)	r or Rural Route Number,
	• Hospit	Medical (	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and plant of the death occurred at the time, date and plant occurred at the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date and the time, date a			
	To th within To th comp	Me	29b. Signature and title of certifier  29c. License number  M.S. 21903	D	1 /	(Month, Day, Year)
	5 Regist	ate	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Tamar Smith 9000 Franklin Square Drive  31. Date filed (Month, Day, Year)  MAY 0 3 2005	Baltin	nose. W	10,21737

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Stephen Mack Kelly 239 PM April 23 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Franklin Square Hospital Rosedale If Under 1 Year If Under 24 Hrs. 8. Date of Birth Wonth Day, Year North Carolina Social Security Number 6 Say 7. Age (In yrs. last birthday) **Funeral** Months 1₽M 2□F 242-58-1831 65 Yrs Director Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or Itams 23a or 28a-f ahow other traumatic event, It to Madical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Md. Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1907 Hawthorne Road 21040 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 Yes 2₺ No Specify: þ 3 X Widowed 4 ☐ Divorced 2 should be filed within 72 hours and Mental Hygiene. Is marked othar than "natural", Lelly, Stephen 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years truck driver moving business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Swanea Powers C. W. Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 Is n any injury or other traun once. Stephen M. Kelly/son 112 Poinciana Cove, New Smyrna Beach, FL 32169 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 5/3/2005 Baltimore, Md. \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): Edema disease or condition resulting in death) /Medical **Examiner** MI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of): Box 68760 the attending physician Physician/Medicai thet use as t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Tes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X ER/Outpatient 1 XYes 2 □ No 2 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) e Hospital or Attending Pl 24 hours after death. 8 Funaral Diractor: After the 28b. Time of 28d. Describe how injury occurred Certification: Injury Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00598 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21237 Maryland DR Betsy Schrader 9000 Franklin Baltimore Square Drive 32 Registrar's Signature State Registrar

05-02873 RKD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

ΚD			For State Registrar	State of I	Marylan		artmen					giene Reg. No.	00	5	14954
			Decedent's Name (First, Middle, L	ast)							2. Date of Dea				3. Time of Death
	Physici		Paul Leroy K	ohler							APRIL	25°	, 200	(ear	10:50A. M
	/Medic Examin		4a. Facility Name (If not institution, g		9r)		4b. City,	Town, or	Location of	of Death			County of		
	Z.Xajiiii	Ŭ.	2708 TERRA VISTA	DRIVE			BALD					1	· IARFO		
	Funeral				Age (In yrs. I	ast birthday)	If Under	1 Year	If Under		8. Date of Birt	h			place (State or Foreign ntry)
	Director		218-72-9071	1 <b>∑</b> M 2□F	45	Yrs.	Months	Days	Hours	Min.	(Month, Da)			Coui MD	ntry)
	ը .		Usual Residence of Decedent								1ug. 10	9 17		1110	
	show	_	10a. State 10b. County		10c. City	, Town or La	cation							1	10d. Inside City Limits
	Ba-1-s	cto	MD Harf	ord		Ba1dw	rin								1 ☐ Yes 2 🎇 No
	ii	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of Wh	at Cou	ntry?
	23e	a	2708 Terra Vist	a Drive				210	)13				USA		
	r deg	by Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.:	S. 13.	Was Deced	dent of Hi	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	. 1		- Americ	can Indian,
36	or it	Y.F.	1 Never Married 2 Married	If Yes, Give	-		1□ Yes 2				, ,		Specify:	_	
21215-0036	within 72 hours after death with the Maryland ene. tten "naturel", or Items 23e or 28e-f show tte Markel Examinational barrollified at	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Date	s:										
5	"nat	Completed	15. Decedent's (Specify anly highest of	rade completed)		16a. Deced	ient's Usua kind of woi DO NOT us	i Occupa rk done d	ition <i>luring mos</i>	t of workii	ng	16b. Kir	nd of Busi	ness/In	dustry
12	withie	E G	Elementary/Secondary (0-12)	College (1-4d N/								m - 1			
2	Hygir ther int,		17. Father's Name (First, Middle, La.	<del>-</del> -	Α.	Wareh	ouse	Mana		ar's Nama	(First, Middle,				ication
au	d be	) Be	Paul M. Kohler	•								warden i	Juli alilo)		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23e or 28e-1 show or other traumatic event, the Marcal Examination and the notified at	မှ	19a. Informant's Name/Relationship	(Type Print)		19h Mailie	a Address	/Street 2		h Cai	I I Route Numbe	r City or	Tour C	toto 7i-	Codel
Ma	d 2 s th an t7 is trau		Pat Buser/Sist												Code)
	1 and Health em 27		20a. Method of Disposition	er	20b. PI	lace of Dispo	sition (Nan	ne of			Bel Ai				own, State
Baltimore,	Pages nent of I int: If its iry or o		1 ☐ Burial 2 🎇 Cremation 3		te Baî	emetery, crer timore	matory or or Wash	ther place	on A	pril	29,				
豊	it. P.		* 4 □ Donation 5 □ Other (Special Signature of Funeral Service 1/10		Cre	matory				200	)5	L	aure.	L, M	ID
Ba	permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any injury or other trau		100			Le	. Name an	Fune	ral 1	Home	of Dula	aney	Val:	ley.	Inc.
			Lemmon Funeral Home of Dulaney Valley, Inc Mychael J. Flagle  Lemmon Funeral Home of Dulaney Valley, Inc 10 W. Padonia Road Timonium, MD 21093  23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximately 1. The proving th												
			shock, or heart failure. List on	y one cause on each	n line.							rest,			Approximate Interval Between Onset and Death
	Physician /Medical	3 1	Immediate Cause (Final disease or condition resulting in death)	a. Coin	tact	gun	shot	WIL	1447	o l	usol				Shoot and South
	Examiner		1	Due to (or	as a consequ	uence of):									
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	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	240 10 (01	40 4 00113044	201100 01).									
	be executed icien and burial-transit	xar	that initiated events resulting in death) Last	c Due to (or	as a consequ	uence of):								-	
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ox (	leath certific attending pl	Physician/Me	IF FEMALE:	23c. If yes, outcor	ne of pregnar	ncv				_			2d D-4-	of doth	
Bo	atter for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal	death 3	Ectopic pro					2	3d. Date Month		ery Day Year
o.	that the dead by the detached	iysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknowr		Julii 3	Otrioi (api	oony)							
Δ.	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit		Part II. Other significant conditions	contributing to deatl	h but not resu	Ilting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco us	e contrib	ute to the	he cause of death?
Records,	uires 1 sign 1d be	d by									1 🗆 Y	es 2	INO 3	☐ Prot	pably 4 Unknown
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Re	has ge 2 :	mp									24a. Was autop	sv	prie	or to cor	psy findings available mpletion of cause of
a			22.11									2 🗆 No	X	ath? ] Yes	2 No
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only or				
o	Phys this ral di	To	1X Yes 2 No 27. Manner of Death	1lnpa		ER/Outpatien 28b. Time of		M	4 🔲 Nu	T	ne 5 Resid				WSCENE
no	ding After fune	tion	1 □ Natural 5 □ Pending	28a. Date of I	0-1 - 1-	Injury		8c. Injury Work 1 🔲 Y		,9	od. Describe II	ow injury	occurred	1	
is S	uttendl death. ctor: A y the fu	cal	2 Accident investigate 3 Suicide 6 □ Could not	be age Bless of		The 1650			05 2		hbject	) ho-	1 34	1	al Route Number,
Division	or A after Direction by	Certification:	4 Homicide determine	building,	etc. (Specify	1 /		, onice			City or Tow	m, State)	3200	Terr	G VISTA
	ours ours erel filled		29a. Certifier 1 ☐ Certifying (	hysician: To the he	est of my know		ine	at the tim	o data an			alda		MI	A-A
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Medical		Physician: To the be eminer: On the basis and manner	s of examinat	ion and/or inv	estigation,	in my op	o, date an pinion, dea	u piace, a th occurre	ed at the time, o	date and	nio mann place, an	d due to	the cause(s)
	o the o the omple	Me	29b. Signature and title of certifier	wild maillille	-,4,00.		29c	License	number	_		29d. Date	signed /	Month	Day, Year)
	F 3 F 8		7.1	11081	1 -	_									
	n		30. Name and address of person wh	completed assured	of dooth //to=	220) (Time	Drien)	OC	ME		A	TKIL	. 26,	200	J5
	17		7 ARIL CIA	o completed cause of	oeath (Item	23a) (1ype,		Pann	C+~~	\^+	Bol+4	100	M	. 7	1 01001
	Sta	to	31. Date filed (Month, Day, Year)	32 Regi	strar's Signat	ture _		r CHII	JLLE	ECL	Daltimo	ore,	mary	Lane	d 21201
	Registr		MAY 0 3 2	005	strar's Signat	Sho	60								

DHMH 17 Rev 1/2001

	1 - For State Ragistrar	State of M		artment of Health	h and Mental Hyg	iene 005	14955		
Physiciar /Medica			KINDER	VATTER	2. Date of Deat Month		3. Time of Death 2:50am M		
Examine	4a. Facility Name (If not institution, 715 Maiden Choi	ce Ln.	e (In yrs. last birthday)		on of Death	4c. County of Death Baltimor	е		
Director	215-09-1144  Usual Residence of Decedent  10a. State 10b. County	1□M 2⊠F	91 Yrs.	Months Days Hou	der 24 Hrs. 8. Date of Birth (Month, Day, June 6,	1913 Maryl			
ith the Maryla or 28a-f sho	MD Baltime	ore	Catonsvil		1	0g. Citizen of What Coun	0d. Inside City Limits 1 □ Yes 全域 No atry?		
itams 238	715 Maiden Cho	12. Was Decedent Amed Forces?  ed 1 Yes 2 If Yes, Give	No		Origin? (Specify Yes or No- ican, Puerto Rican, etc.)	USA  14. Race - Americ Black, White,  Specify: whi	etc.		
Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental Hygiene. 77 Is marked other than "natural", or traumatic event, it e.m. dical Excent	3 Widowed 4 Divorced  15. Decedent  (Specify only highes)  Elementary/Secondary (0-12)	College (1-4or 5	16a. Dece (Give life.	dent's Usual Occupation kind of work done during n DO NOT use retired)		16b. Kind of Business/Inc			
aryland 2 should be filed v and Mental Hygie s marked other; umatic evant, to	17. Father's Name (First, Middle, L Henry Kinderva	•	LT. Co	18. Mo	other's Name (First, Middle, Maristina V. Bo				
ore, Mary ss 1 and 2 sho of Health and litem 27 is m r other treums	19a. Informant's Name/Relationsh George E. Foss 20a. Method of Disposition		2204 20b. Place of Dispo	Belleview Rd	mber or Rural Route Number.  L. Catonsville  Date		21228		
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men important: if item 27 is marka any injury or other traumatic.	1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sc 21. Signature of Funeral Service)	ecity)	Loudon Oa	2. Name and Address of Fa	May 5, 2005 B	altimore Ci Funeral Ho	ty		
Pnysician /Medical Examiner	23a. Part1. Enter the disease, or shock, or heart lailure. List of Immediate Cause (Final disease or condition resulting in death)	Ver	the death. Do not entine.	ter the mode of dying, such	TH METASTATIO	est,	Approximate Interval Between Onset and Death		
876(	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	consequence of):	R-NON for	mu lill				
BOX 6 ath certifi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Vo 9 Unknown	23c. If yes, outcome 1 ∐Live birth 4 ∐Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	-		23d. Date of delivery Month Day Year		
wrequires that the debeen signed by the a	Part II. Giner significant condition	En		nderlying cause given in Pa	art I. 23e. Did tob	pacco use contribute to the			
		VBSTPMCTI	i sung	NISEMSE		y prior to con death? No 1 ☐ Yes	psy findings available npletion of cause of 2 No		
on of ding Phys	examiner?	ation NI	ry 28b. Time o	ot 3 DOA Other: 4 D	ace of Death Check ont one  Nursing Home Reside  28d. Describe ho	nce 6 Other (Specify	)		
Division Control of Attanding P within 24 hours after death. To the Funeral Diractor: After to completely filled in by the funeral Mardical Certification.		ned 289. Place of Inj building, et	N/B	2	28l. Location (St. City or Town and place, and due to the ca	NIG			
To the Hospital within 24 hours a To the Funeral completely filled	one) 29b. Sign. I re and titl. of ce offier	and manner sta	r examination and/or in ated.	29c. License number	er 29	ate and place, and due to ad. Date signed (Month, L	the cause(s)  Day, Year)		
12	30. Name and address of person v	no completed cause of d	eath (Item 23a) (Type,	110025	995 PREK DRIVE;	05.02	M- 2005		
State Registrar	MAVA	2005 32 legistr	ar's signature	V VIIIV PA	TAK WRIGE;	DATTMORE	1810, 2121		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Year 2005 /Medical Donald Joseph Koch, Sr. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner n/a Stella Maris @ Mercy Hospital Baltimore H Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 10, 1926 6. Sex 1 M 2 F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Yrs. 78 Director 219-10-4540 Maryland Usual Residence of Decedent 10a, State 10c, City, Town or Location 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Baltimore Maryland n/a 1. Yes 2 No Director 10f. Zip Code 21230 10g. Citizen of What Country? United States 10e. Street and Number 600 Light Street Apt. 227 or itame 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: Year or Dates: Navy 3 ☐ Widowed 4 ☐ Divorced natural White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, II a Neulic once. n/a Elementary/Secondary (0-12) B&O Railroad Machinist years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick Koch Veronica Rowan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 Light St. Apt 227 Baltimore, Maryland 21230 Anna E. Koch (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tXXBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 5-4-2005 Brooklyn Park, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
130 E. Fort Ave. Baltimore, Maryland of Euneral Service Licensee J. Wayne Osterling 21230 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pock, or help it failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final disease or condition resulting in death) Priysician Cancel /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown ά Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 99 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has 2 No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 ☐ Yes 2 ☐ No this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After 1 -Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2005 291 30¢ Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar Stewn & Sporte

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	Ī	Physic		1. Decedent's Name (First, Middle,	Crop	Feld	es					2. Date of De		Year 2304	3. Time of Death
		/Medi Examir		4a. Facility Name (If not institution, s	give street and number	1 -1-				Location o	of Death	171111	4c. Coun	ty of Death	
		Funeral Director		5. Social Security Number 216-16-0857	1. Sex 7. A	ige (In yrs. last	birthday) Yrs.	If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir January	th 4.6,°° 924	9. Birthi Cou	place (State or Foreign ntry) LBC
		and		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation							Od. Inside City Limits
		death with the Maryland ma 23a or 28a-f show I must be notified at	tor											1 ☐ Yes 2 🛣 No	
		ith the	Direc	10e. Street and Number				10f. Zip					10g. Citizen o		ntry?
A.M		a 23a	rai	5 Gandson Cou				210	_				U.S.		
10:00	5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Itema 23a or 28a-f show amportant: if Item 27 is marked other then "natural", or Itema 23a or 28a-f show amply injury or other traumatic event, if a Medical Exercities must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	it Ever in U.S. i? ≹No :		Was Decede If Yes, spect		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		ice - Americ ack, White, ify: Whi	etc.	
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2		be filed ital Hygi id other event, I	Be C	17. Father's Name (First, Middle, La	st)					18. Mothe	r's Name	(First, Middle,	Maiden Suma		
2005	Maryland	should band Ments marked umatice	To	Teofil		iewicz					arya			Sobj	
	Mar	d 2 sh th and t7 is m traum		19a. Informant's Name/Relationship Robert J. Kropfelde		1							er, City or Town		Code)
29	ē,	s 1 an f Heal fem 2 other		20a. Method of Disposition		20b. Place	of Dispos	sition (Name	e of			ate	20c. Location		wn, State
APRIL	mo	Page nent o ant: If ary or		1 ☐ Burial 2 ☐ Cremation 3  '4 ☐ Donation 5 € Other (Spe	Removal from State	9	ev Val	natory or oth Llev	ner place	"	5/2/0	5	Timoni	m. MD	
API	Baltimore,	permit. Departn Imports any inju	li	21. Signature of Funeral Service Lie			22	. Name and			<b>Ruck</b>	Tawsan	Funeral		nc.
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		/Medical Examiner		23a. Part1. Enter the disease, or or shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	s a consequence	1-	)em		+ i a	cardiac o	r respiratory ar	rrest,		Approximate Interval Between Onset and Death
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	Box 68760,	ath certific attending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ② No		e of pregnancy 2  Fetal dea	ath 3	Ectopic pred						ate of delive	ry Day Year
OR	P.O.	that the de ted by the a	hysi	9 Unknown	9☐ Unknown		_	, (0,000	//						
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KROPFELDER,	ion of	ing Ph After th funeral	H +	27. Man er of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da		Time of Injury		c. Injury Work		2		lence 6 Otl		')
	Division		Certification:	3 Suicide 6 Could not determine	28e. Place of in	ijury - At home, tc. (Specify)	farm, stre	eet, factory,	office		2	8f. Location (S City or Tow	Street and Num m, State)	ber or Rurai	Route Number,
		To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	one)	Physician: To the best aminer: On the basis of and manner st	or examination :	dge, death and/or inv	estigation, in	n my opi	nion, deatl	place, a	d at the time, o	date and place,	and due to	the cause(s)
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	4	27'		30. Name and address of person wh	T, $M.D$ .	2300 1	DULAN	EY VA		ROAL	D	TIMONI	UM MD	2109	3
		Sta Registr		31. Date filed (Month, Day, Year)	32. Redistr	rar's Signature	4 A	code							

	1	State of Maryland / Department of He  State Registrar  Certificate of Department  Certificate of Depar	alth and M	lental Hygi		14958			
Physicia /Medica Examine	n al	1. Decedent's Name (First, Middle, Last)  Gretchen Maria Kess  4a. Facility Name (If not institution, give street and number)  OUTER LOOP I-695 S/B WINDSOR MILL RD  4b. City, Town, or Lo		2. Date of Death Month APRIL	28, 2005 4c. County of Dea				
Funeral Director		5. Social Security Number 6. Sex 1 $\square$ M $\square$ F $\square$ Age (In yrs. last birthday) $\square$ If Under 1 Year 1 $\square$ Months Days Usual Residence of Decedent	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 7 / 20 / 1	BALTIMORI 9. Bir Co 961 Bal	thplace (State or Foreign buntry) timore, Md			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death or Maryland Mental Hygiene. Inportant: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event. In Medical Examinar must be fullified at once.	Funeral Director	Md .         AACO         Glen Burnie           10e. Street and Number         10f. Zip Code           7623 Spencer Road         21061           11. Marital Status         12. Was Decedent Ever in U.S. Armed Forces?         13. Was Decedent of Hisp If Yes, specify Cuban, If Yes, specify Cuban, If Yes, specify Cuban, If Yes, specify Cuban, If Yes, specify Cuban, If Yes, specify Cuban, If Yes, specify Cuban, If Yes, specify Cuban, If Yes, specify Cuban, If Yes, specify Cuban, If Yes, specify Cuban, If Yes, specify Cuban, If Yes, specify Cuban, If Yes, specify Cuban, If Yes, specify Cuban, If Yes, specify Cuban, If Yes, specify Cuban, If Yes, S	anic Origin? (Spo Mexican, Puerto		USA  14. Race - Am Black, Whi	erican Indian,			
of 2 should be filed within 72 hours after the and Mental Hygiene.  17 Is marked other than "natural", or it traumatic event, the Medical Examin	Completed by Fu	1 □ Never Married       1 □ Yes 2 No         3 □ Widowed       4 □ Divorced       If Yes, Give Year or Dates:         15. Decedent's Education (Specify only highest grade completed)       16a. Decedent's Usual Occupation (Give kind of work done durnifie. DO NOT use retired)         Elementary/Secondary (0-12)       College (1-4or 5+)         12       Nurse	Specify:	Specify: B		ack /Industry			
nd 2 should be file alth and Mental Hy 27 Is marked othe r traumatic event,	To Be	17. Father's Name (First, Middle, Last)	Lillie d Number or Rura	e (First, Middle, M M. Spe al Route Number,	ncer City or Town, State,	Zip Code)			
permit. Pages 1 ar Department of Hea Important: If Item: any Injury or other	-	20a. Method of Disposition    X   Burial   2   Cremation   3   Removal from State	5/6/0	Oate 2	oc. Location - City or	Town, State Md.			
/Medical /Medical Examiner pnujar-Itausit	Examiner	23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	FTACE such as cardiac o	, DAIL IIII	ore, mq.	21217 Approximate Interval Between Onset and Death			
death certificete be e attending physicle d for use as the bur	Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			23d. Date of de Month	f delivery Day Year			
requires the been signed should be d	٦	þ	ompleted by Physi	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I.		24b. Were a	o the cause of death?  robably 4 Vunknown  utopsy findings available completion of cause of
tal or Attending Physician: rs after death. el Director: After this certifics ed in by the funeral director.	Certification; To Be C	Additional and the state of the	4 Nursing Ho	Toperform  1  Ves 2  h (Check only one me 5  Resider 28d. Describe how  Web 2  28f. Location (Str. City or Town,  wand due to the ca	ned? death?    No   1 Dives   No   1	ural Route Number,			
To the H within 24 To the Fi complete	Medical	29b. Signature and title of certifier  29c. License n  OCME  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	umber	AP	Pd. Date signed (Mont PRIL 29, 2	th, Day, Year)			
Stat Registra	e ar	31. Date filed (Month, Day Year) iMAY 0 3 2005  ORIGINAL	ALTIMORE	, MARYLA	ND 21201				

State of Maryland / Department of Health and Mental Hygien 1 959 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AMPT 18, 2005 Year 8:35 А. м F. Mercella Leach /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Silver Spring Mantgamery Fairland Nursing Home If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🐼 🐔 73 578-78-1443 Yrs. Director September 10,1931 Jamaica Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or Items 23a or 28e-f show the Medical Examiner must be notified at Takoma Park Maryland Montgomery 1 ☑ Yes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20912 U.S.A. 6617 Allegheny Avenue by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Black 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hair Stylist CosmetoLogy permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygien
Importent: if item 27 is marked other it
eny injury or other treumetic event, Item
once. 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wilma Anderson Richard Flemming 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3721 36th Street Mount Rainier, Maryland 20712 19a. Informant's Name/Relationship (Type, Print) Dorrel Nolasco (Friend) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Washington National Cemetery April 22, 2005 Suitland, Maryland ' 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rollins Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4339 Hunt Place, N.E. Washington, D.C. 20019 1). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cercbroviscular Accident /Medical Due to (or as a consequence of): Examiner Arrial Fibrillation Sequentially list conditions, if any, leading to immediate the second sec Due to (or as a consequence of) Examiner to the Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Cardionyopathy and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2XXNo 23d. Date of delivery 3 Ectopic pregnancy igned by the atte Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√∑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funerel Director: After thi completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number April 29, 2005 D58962 S. Patel, MD Name and address of person who completed cause of death (Item 23a) (Type, Print) Shashan Patel 2309 Shorefield Road Wheaton, MD 20902 31. Date filed (Month, Day, Year) State Registrar MAY 0 3 2005

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien® For State Registra 14960 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Gloria 28 April 2005 03:55AN /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltmore
If Under 1 Year | If Under 24 Hrs.
Months Days | Hours | Min. Daltimore Sinai 01 Hospital NA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 216-13-6742 1 □ M 2 🔀 F Director 18 6-29-86 Md Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at Director Md. NA Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 5721 New Holme items 23a Ave. 21206 Funeral USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married ☐ Yes 2 📉 No Yes, Give 'ear or Dates: Baltimore, Maryland 21215-0036 ō 1 Yes 2 No Specify: Completed by 3 □Widowed 4 □Divorced Specify: Black 'naturei', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Student 12th grade NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Patrick Westmoreland 2 Sabrina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at Important: If item 27 is any injury or other trau Sabrina Little 5721 New Holme Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Magazian 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Faith 5-6-05 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21.202 y la Warne March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Priysician disease or condition resulting in death) month /Medical Due to (or as a consequence of): Examiner Pulmonary pleural fibrosis 3 mouth and Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examine physician and the burial-transit The law requires that the death certificate be executed osteogenic Sarcoma resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as t attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 1 ed by the a detached f 9 Unknown 9 🗌 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ signdrome cate has been sig , page 2 should b Fanconi-like 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy
performed?
Yes 2 \( \sqrt{N} \) certificate 1 Yes Hospital or Attending Physicien: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1. Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Chewioth Rick Sman D47128 - aus April 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. Glicksman, 2401 W. Belvedere Ave. B2 m.D. Baltimore, VMd. 21215 31. Date filed (Month Div Year) 3 32. Restrar's Signature State 2005 Registrar

State Registrar

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erson who completed cause of death

31. Date filed (Month, Day, Year,

		1 - For State Registrar	State of Marylan		artmen <i>rtificati</i>				gien <b>e</b> () (	)5	14962
Physic		1. Decedent's Name (First, Middle, Last)	LAWR	ENIC	F	TR	)	2. Date of Dea Month	ath Day	Year -	3. Time of Death
/Medi Examir		4a. Facility Name (If not institution, give s	treet and number)	2.00	4b. City,		ocation of Dea		4c. County	y of Death	111
Funeral Director		2159 McKendree Ro 5. Social Security Number 6. Sex 577-64-1652	7. Age (In yrs.	last birthday) Yrs.	If Under Months		endship If Under 24 Hr Hours Min		h Vearl	9. Birthp Coun DO	place (State or Foreign utry)
/land		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
e Man Ba-fsh Hiffed	ctor	MD Howard		West 1	rien	dship					1 ☐ Yes 2√☐ No
with the	Director	10e. Street and Number 2159 McKendree Ro	ad		10f. Zip	Code 2179	1/1		10g. Citizen of USA	What Coun	itry?
13-UUJO 172 hours after death with the Maryland "netural", or Itams 23e or 28a-f show olicel Exanitret: has be truffiled at	by Funerai		2. Was Decedent Ever in U Armed Forces? 1 XYes, 2 □ No If Yes, Give Year or Dates: Kore		Was Deced f Yes, spec 1 ☐ Yes 2	lent of His city Cuban		Specify Yes or No- rto Rican, etc.)	14. Rad Bla	ce-Americ ick, White, fy: Whit	etc.
- S - 3	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	16a. Deced (Give life. I	kind of wor DO NOT us	rk done du se retired)	ion uring most of wo	i i	16b. Kind of B		dustry
be filed tal Hygi d other	o Be Co	17. Father's Name (First, Middle, Last) Sydney Lawren	ce, Sr.	riai	iuraci		<u>-</u> _	me (First, Middle,	Maiden Sumar		
ire, Marylan s 1 and 2 should be if Health and Mental itam 27 is markad other traumatic ev	F	19a. Informant's Name/Relationship (Type Mrs. Helen Saters-	(Spouse					oural Route Number Vest Frie			Code)
Pages 1 ar nent of Hea int: If itam.		20a. Method of Disposition  1 \( \Delta \) Burial 2 \( \Cremation \) Cremation 3 \( \Delta \) Re (Specify)	20b. F	Place of Dispo	sition (Nan	ne of ther place.	-	Date	20c. Location	- City or To	
Dermit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service License	auxt	1 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	Name and isht	d Address Fune ille,	of Facility ral 1100 MD 217	84 (410)	e1 -795 <sup>P</sup> 14	ioo (Bc	x 195)
Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	CARD	h. Do not ent	er the mode	e of dying,	such as cardia				Approximate Interval Between Onset and Death
Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of the to (or as a consequence of	CAN	CER	_					
utificate be executed by physician and as the burial-transit	ai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq		NIAL METASTASES						
ath cer ttendir	hysician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	dc. If yes, outcome of pregnating the birth 2 □ Feta 4 □ Fregnant at time of degree of the birth of the birt	I death 3	Ectopic pro					ate of delive	ory Day Year
S, T	by P	Part (I. Other significant conditions conf	tributing to death but not res	ulting in the u	nderlying ca	ause given	in Part I.		bacco use con	tribute to th	e cause of death?
The law ate has be page 2 s	Completed							24a. Was a autop perfor	sy magd2	Were autor prior to con death? 1 \( \text{Yes} \)	osy findings available npletion of cause of 2 No
	o Be	25. Was case referred to medical examiner?	ospital: 1   Inpatient 2	ER/Outnation	t 3 🗆 DO			ath <i>(Check only or</i>			
ding After fune	ation; T	27. Manner of Death 1- Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury a Work?	at es 2 □ No	28d. Describe h			)
To the Hospital or Attending within 24 hours after death. To the Funaral Diractor: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street, factory, office City or Town, Sta					n, State)			
e Hosp 24 hou a Funar etely fill	ledicai	29a. Certifier 12 Certifying Physic (Check only one) 2 Medical Examin	icien: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred a vestigation,	at the time in my opir	, date and plac nion, death occ	e, and due to the durred at the time, d	ause(s) and madate and place,	anner as sta and due to	ated. the cause(s)
To th within To th.	Me	29b. Signature and title of certifier	V-S		290	License i	A178		29d. Date signe	d (Month, L	Day, Year)
19		30. Name and address of person who cor	mpleted cause of death (Item	1 23а) (Туре,	Print)						
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture (	alum	MIC	100 4	ky Tui	RN,	volum	ML ML1
Regist	rar	VARR	no some		As a	Land M.	D				

DHMH 17 Rev 1/2001

			1 - For State of Maryland		artment of H		ind M		ene	) 5	14963	
	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> DANIEL JEROME MIELKE					2. Date of Death Month MAY	Day	Year	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of	f Death	/ ////	4c. County		7.10	
ľ			GOOD SAMARITAN HOSPITAL		BAK	TIMOV	RE			NI	9	
	Funeral Director		5. Social Security Number 6. Sex 214–14–2956 1. Sex 2□ F 8	st birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, 10-29-1	Year) 1920	Coun	lace (State or Foreign try) RYLAND	
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Lo	cation					11	0d. Inside City Limits	
	e Maryi 8a-1 sho	Director	MD BALTIMORE			SPEBU	RG			1 □ Yes 2 ☐ <b>X</b> No		
	with th		10e. Street and Number		10f. Zip Code	0400	_	10	g. Citizen of \		try?	
	eath v	Funeral	4226 WOODLEA AVENUE  11. Marital Status  12. Was Decedent Ever in U.S	13.1	Was Decedent of Hi	2120		cify Yes or No-		S.A.	an Indian	
396	2 should be filed within 72 hours after death with the Maryland and Menth Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Madical Examiner must be notified at	þ	Armed Forces?  1 □ Never Married 2 ★ Married 1 □ Yes 2 ★ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2☐XNo	Specify:	, Puerto I	Rican, etc.)		ck, White,	etc.	
2-0036	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa kind of work done of OO NOT use retired	ation during most	of working	ng	6b. Kind of B	usiness/ind	dustry	
2121	d within giene. or than '	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	MAINTEN				CITY PUBLIC SCHOOLS			
Maryland 21	should be filed ind Mental Hyglis marked other umatic event, III	To Be (	17. Father's Name (First, Middle, Last) WILLIAM A. MIELKE				r's Name GNES	(First, Middle, M	laiden Suman BENDA )	те)		
lan	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any Injury or other traumatic. once.	Ì	19a. Informant's Name/Relationship (Type, Print)		g Address (Street a						ŕ	
_	1 and Health em 27 ither tr		VICTORIA MIELKE/ WIFE  20a. Method of Disposition 20b. Pla		WOODLEA sition (Name of	AVENU.		BALTIMOF	RE, MD	212		
altimore,	Pages nent of I int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	metery, cren	oF FAITH		5–4		BALTIM			
# #	permit. P Departme Importan any Injur	9	21. Signature of Fursial Service Licenses		. Name and Addres	1	-					
ä	Depa Impo any ir		165		211 CHESA				DALE,		1237	
	Physician /Medical Examiner	iner	23a. Part. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	mence of):	er the mode of dying					L	Approximate Interval Between Onset and Death	
8760, <	cate be executed obysician and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last   C. Due to (or as a consequence of the consequence of	ence of):								
õ	ing ph		IF FEMALE:									
O. Box	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of delivery Month Day							
rds, P.	w requires that to be the signed by should be detailed	by	Part II. Dther significant conditions contributing to death but not result		23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Anknown							
Record		Completed						24a. Was an autopsy perform	ed?	prior to con death?	psy findings available inptetion of cause of	
Vita	ysician: Thatis certificate	Be (	25. Was case referred to medical examiner?				of Death	(Check only one				
	Physi this c	۲.	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 XE	P/Outpatien		4 🗀 1401		ne 5 Resider			)	
LO O	Attending Physician: r death. ector: After this certific. by the funeral director.	tion	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation	Injury	28c. Injury Work M 1 🗍			8d. Describe ho	w injury occurr	rea		
Division of	or rifte in	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str		1 Yes 2 No fice 28f. Location (Street and Number or Rural Route Num City or Town, State)					Route Number,	
	Hospita 4 hours Funeral ely fillec	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my know Medical Examiner: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the time restigation, in my op	ne, date and pinion, death	i place, a h occurre	and due to the ca ed at the time, da	use(s) and ma te and place,	inner as sta and due to	ated. the cause(s)	
	To the He within 24 To the Fu	Me	29b. Signature and title of certifier		29c. License	e number		29	d. Date signe	d (Month, L	Day, Year)	
		l III	Stephen 11- 4 1	P.D.	$\mathcal{U}$	426	58	1	MAY 3	200	75	
	8		30. Name and ad ress of person who complete use of death (Item 2)	23a) (Type, 5 & C	Print) LOCH	Ravi	ein	Blud B	altin	iore d	11)21239	
	Sta Registr	- 3	31. Date filed (Month, Day, Year)  MAY 0 3 2005	ire								

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Maryla		artment of F rtificate of		nd Mental Hyg	iene	15	14964
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	Day	Year	3. Time of Death
ı	/Medic Examin		Blanche Elizabet  4a. Facility Name (If not institution, give:				4b. City, Town, o	r Location of D	Aphil	29 Th	2005	4-45 AM
		>	Union Memorial H	lospital				altimo)			N/A	
	Funeral		5. Social Security Number 6. Sec	7 M 20XF		. last birthday) Yrs.	If Under 1 Year Months Days		Min. (Month, Day	Year)	9. Birthp	lace (State or Foreign
	Director		215-12-1018 Usual Residence of Decedent		83	113.		<u></u>	Dec. 21	, 1921	10	owa
	aryian ahow dat	_	10a. State 10b. County		10c. C	ity, Town or Lo	cation				1	Od. Inside City Limits
	h the Maryland or 28a-f ehow	Directo	Maryland N/A					imore				1∭Yes 2☐No
	3a or 3	Dir	3422 Erdman Avenu	2			10f. Zip Code	2121		0g. Citizen of		·
	after death with the Maryland or Items 23a or 28a-f ehow miner must be notified at	Funeral		12. Was Deced Armed Ford	ent Ever in l	J.S. 13.	Was Decedent of H		? (Specify Yes or No- querto Rican, etc.)	14. Rac	S. A	an Indian,
30	s after	by Fu	1 Never Married 2 Married	1 Tyes 2	Ø No		1 Tes, specily Cuba 1 □ Yes 2 X No	Specify:	deno Alcan, etc.)	Specif	ck, White,	
5-0036	within 72 hours after death with ene. than "natural", or items 23a or than "natural", or items 13a or	ed p	3 X Widowed 4 ☐ Divorced	Year or Date	9S: 	16a, Decer	ient's Usual Occup	ation		16b. Kind of B	wn	ite
212	thin 72 e. an "na Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)		or 5+)	(Give	kind of work done DO NOT use retired	during most of	working	TOD. KING OF B	usiness/inc	ustry
Z	e filed wi if Hygien other th		6th Grade				Homema				n Hom	e
and	d be fi	o Be	17. Father's Name (First, Middle, Last)  John Burt Schrol	D					Name (First, Middle, 1 Zabeth Emm		*	
ar	shoul and Me s mark	Ţ	19a. Informant's Name/Relationship (Ty)			19b. Mailin	g Address (Street		r Rural Route Number			Code)
Ž,	and 2 Balth a n 27 is		Joan Rose McCully	(Daught	er)				Baltimore			
ore ore	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other ance.		20a. Method of Disposition 1	emoval from St	20b.	Place of Dispo	sition (Name of natory or other place	08)	Date	20c. Location	- City or To	wn, State
Saltimor	permit. Pages Department of Important: if i any injury or once.		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		va	Ga	alley Mei rdens	5	/3/2005	Timoni	um, M	aryland
ă	Depa Impo any ir			 wer		3	331 Rroh	ms land	Schimunek F 2, Baltimor	uneral	Home	Inc.
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that cau	sed the dea	th. Do not ente	er the mode of dyin	g, such as car	diac or respiratory arre	est,	grana	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Λ .		Pneu						Onset and Death
	/Medical Examiner	Jer	resulting in death)	Due to (or	as a consec	quence of):		0 . 6		43.1		
			Sequentially list conditions, if any, leading to immediate	Due to (or	as a conse	quence of):	ling C	Keipick	ventricula	1 Rhy	they	1 WK
	and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Hyp	onata	emia	C salt	loosing	nephropa	thy)		3 months
8/00,	icate be executed physician and the burial-transit		resulting in deathy cast	Seve	0	quence of):			, ,			dau
200		edicai	d	. Jeve	ce N	/1						10 yrs
ZOZ	death certifi e attending od for use as	ician/Me	200. Was decedent pregnant	3c. If yes, outco 1⊟Live birt	me of pregn		Ectopic pregnancy			23d. Da	te of deliver	у
	w requires that the death certif been signed by the attending should be detached for use a:	sici	in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	4□ Pregnar 9□ Unknow	t at time of o		Other (specify)			Мо	onth (	Day Year
	that the	y Physi	Part II. Other significant conditions con	tributing to deat	h but not res	sulting in the un	derlying cause give	en in Part I.	23e. Did tob	acco use cont	ribute to the	e cause of death?
ecords,	quires an sign	ed by							1 ☐ Ye	s 2 No	3 🗌 Proba	ably 4 Unknown
သ သ	law re as ber 2 sho	Completed							24a. Was ar autops	24b.	Were autop	sy findings available
ב =	: The cate h	Соп							perform	ied?	death? 1 ☐ Yes 2	pletion of cause of
्राध्या राह्या	sician certifi irector	o Be	25. Was case referred to medical examiner?	ospital:			2CI DOA Othe	2.00	Death (Check only one			
5	g Physer this eral d	- 1	27. Manner of Death	28a. Date of	njury	ER/Outpatient 28b. Time of	3□ DOA 28c. Injun Work	4 LI NUISIII	g Home 5 Reside			
VISION	andin sath. or: Aft he fun	atlo	1 XNatural 5 Pending investigation	(Month,	Day Year)	Injury		<br Yes 2□No				
ž Ž	or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of building	Injury - At h	ome, farm, stre	et, factory, office		28f. Location (Str City or Town	eet and Numb State)	er or Rural	Route Number,
_	To the Hospital or Attanding Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.		29a. Certifier 1 Certifying Phys	ician: To the be	est of my kn/	owledge death	occurred at the tim	o date and pl	ace, and due to the ca			
	he Ho n 24 h he Fui pletely	edicai	(Check only 2 Medical Examinone)	er: On the basi and manner	s of examina	ation and/or inv	estigation, in my or	pinion, death o	ccurred at the time, da	te and place,	and due to t	ted. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	2010	N/A	1 0	29c. License			d. Date signed		
			Dangaria Ken				1172	4380	146 1	tpril	29th	2005
	30		30. Name and address of person who con Kamal Danger	ia, u	D -	Win			Hospital			
	Sta	e	31. Date filed (Month, Day, Year) MAY 0 3 200	36. Reg	istrar's Sign		Ro					
	Registra	-		1 1 12	South Ash	- A 1 1 1 1 1 1 1	10					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 3:42 PM **Physician** 2005 Matuski Inna /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number **Examiner** ANNE ARUNDEL HAMMONDS LANE GENESIS ELDERCARE BROOKLYN Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 M 2 F Yrs. FEB 24, 1906 MD 99 Director 217.54.2574 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b, County 10a. State Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director BROOKLYN ANNE ARUNDEL MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21225 1 7TH AVE by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XXXVo If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No ò Maryland 21215-0036 Specify WHITE 3¥Vidowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) OWN HOME HOMEMAKER 6 . Pages 1 and 2 should be filed v tment of Health and Mental Hygie tent: If Itam 27 is marked other t jury or other traumatic svent, IL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARGARET MARY DECKER 2 lınk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 7TH AVE BROOKLYN, MD 21225 JOAN SUIT DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 20a. Method of Disposition GLEN BURNIE, MD GLEN HAVEN CEMETERY 5.3.2005 permit. Page Department o Importent: If any injury or ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice FINK FUNERAL HOME, P.A. K. GREGORY FINK 426 CRAIN HWY SW GLEN BURNIE, MD 21061 MO1148 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseque **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner the attending physician and ned for use as the burial-transit certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical use as the IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 menths? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death detached 9□ Unknown 9 Unknown signed by t Id be detach 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2₽No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physicien: 26. Place of Death Check on one 25. Was case referred to medical funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ Mo Certification: To this 28c. injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 5 Pending investigation 1 Naturat 1 ☐ Yes 2 ☐ No after death. Director: Af 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Han MAY 0 3 31. Date filed (Month State 03 Registrar

State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DONALD MEYERS 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1/ospita N/AIf Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5/20/39 Birthplace (State or Foreign Country) **Funeral** Hours 219-36-2335 65 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show traumatic evant, the Madical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland ( Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a ( 26800 Crossbill Ct. 21830 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? \*\*Mayes 2 □ No If Yes, Give Year or Dates: **Vietnam** "natural', or Itams 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. her than "natural", or Ita 1 Never Married X Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: ģ 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Depriment of Health and Mental Hygient Important: If Item 27 Is marked other that any injury or other traumatic event, If an 2005. Conductor Railroad 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Meyers Gladys Franklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrtle Meyers Wife 26800 Crosbill Court Hebron, MD 21830 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 remation 3 □ Removal from State Baltimore-Washington 5/2/05 ' 4 ☐ Donation 5 ☐ Other (Specify) Laurel, MD uneral Service Lipense 22. Name and Address of Facility Burgee—Henss—Seitz, Funeral Home, Inc. 3631 Falls Road Baltimore, MD, 21211 21. Signatus Parti. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS 2 days /Medical Due to (or as a consequence of): **Examiner** Cellulitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecuence of) Examiner burial-transit The law requires that the death certificate be executed heart trans, lant and Due to (or as a consequence of) Records, P.O. Box 68760. attending physician Physician/Medical as the l use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy jo Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ renal disease 2 No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? /es 2/2000 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: "within 24 hours after death. To the Funaral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 3 □ DOA Cther: 4 □ Nursing Home 5 □ Residence 6 □Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 2 27. Manner of Death

1 Dinatural

2 Discription 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL 28, 2005 RES -000 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 WOLFESTRUET BALTIMORE, MARYLAND 21287 YULI KIM, MO THE JOHNS HOPKINS HOSPITAL 31. Date filed (Month, Day, Year) 3. Registrar's Signature MAY 0 3 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day . **Physician** MONTHRIL 28,02 12:51FM MARY KELLY MICHELS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral**  Birthplace (State or Foreign Country) 1□M 2√2F 75 214-26-6865 Director 26. 1929 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits other traumatic avant, the Medical Examiner must be notified at Maryland 1 ☐ Yes 21 No Director Baltimore County Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 Pot Spring Road, L630 21093 USA or itams 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours efter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiena. than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic event, Inst. Once. Travel Agent  ${\sf Travel}$ 4 yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Patrick Jeremiah Kelly Agnes Dyer Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph T. Michels, M.D. (Husband) 2525 Pot Spring Road, Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) New Cathedral Cemetery 5/2/2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road, Baltimore, Maryland 21212

Approximation of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximation of the disease of the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximation of the disease of 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE CEREBROVASCULAR HEMORRHAGE **Physician** DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off: Examiner attending physician and for use as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown 3 been signad by should be deta Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by PREVIOUS CEREBROVASCULAR HEMORRHAGE (2004) 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

12 Yes 2 \( \subseteq \) No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending death. investigation 1 ☐ Yes 2 ☐ No I Diractor: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D 34543 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 AXE, M. D., STEVEN R. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

4	State State		ment of Health and M	ental Hygiene	15 14968
	Registrer  1. Decedent's Name (First, Middle, Last)	Centi	ficate of Death	Reg. No.	3. Time of Death
Physician	1. Decedent's Name (First, Middle, Last)	- Moore	<0	Month Day 4 26 ZO	Year 7.17
/Medical = Examiner	4a. Facility Name (If not institution, give street and n	umber) 4	b. City, Town, or Location of Death	4c. County	
	204 APT B TIMBER TRE	AIL	BEL AIR	HAR	FORD
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	f Under 1 Year If Under 24 Hrs. Ionths Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
	Usual Residence of Decedent	SE Yrs.		3-11.194	MARYLAND
/land	10a. State 10b. County	10c. City, Town or Locat	ion		10d. Inside City Limits
Man a-f sh	MD HARFORD	BEL A	R		1 ☐ Yes 2 1 No
with the Mar a or 28a-f si be notified	10e. Street and Number		10f, Zip Code	10g. Citizen of V	
ath w	204 APT B TIMBER		21014	US	
State death viller death viller death viller must	11. Marital Status 12. Was De Armed F	2 🗆 No	s Decedent of Hispanic Origin? (Spe es, specify Cuban, Mexican, Puerto I	Rican, etc.)	e - American Indian, ck, White, etc.
d 21215-0036 d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-1 show ant, the Medical Evanfrer must be notified at any transported by Funeral Director	3 ☐ Widowed 4 ☐ Divorced If Yes, G	live 1	Yes 2☑ No Specify:	Specify	WHITE
21215-00 ed within 72 hou ygiene. Per than "naturan, tra Medical at tra Medical completed	15. Decedent's Education (Specify only highest grade completed	(Give kin	t's Usual Occupation d of work done during most of working	10	isiness/Industry
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d 212 d 212 Hygiene, ther than ant, than	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maiden Sumam	GROWDS
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If item 27 1s marked other than "natural; or any injury or other traumatic event, tra Macilcal Everal once.  To Be Completed by F	GEORGE F.	MODE	ANNIE	E C. HAG	SNER
Tary 2 should and M is man and M is man and	19a. Informant's Name/Relationship (Type, Print)		Address (Street and Number or Rura	Route Number, City or Town,	State, Zip Code) 210 14
and and and martra		VIFE 204 A	PI B TIMBER	TRAIL SEL	AR, MD
Baltimore, sermit Pages 1 at Department of Hes miportant: If item mip injury or oths since.	20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from	20b. Place of Disposition State	ory or other place) 4.3c		City or Town, State
Itimen introduced in the partial interpretation in the partial int	* 4 □ Donation 5 □ Other (Specify)  21. Signature on Funeral Service Licensee	HIGHVIEW	ame and Address of Facility Eva		TON, MD
Balt permit Depart Import any (n) once.	Mal	Mo1220 31	VEWPORT DR.	BELAR M	
	23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not enter t		r respiratory arrest,	Approximate Interval Between Dract and Death
Physician	Immediate Cause (Final disease or condition resulting in death)	Izhlimiri	Demention		10 years
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P.O. hat the od by the detached	9 ☐ Unknown 9 ☐ Unk	nown			
	Part II. Other significant conditions contributing to	death but not resulting in the unde	rlying cause given in Part I.		ibute to the cause of death?
ord requir					3 Probably 4 Unknown
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endin eath. or: Af he fur	2 Accident investigation		M 1 Yes 2 No		
Division of Vital Records, tal or Attending Physician: The law requires the safter death.  at Director: After this certificate has been signed in by the funeral director, page 2 should be certification; To Be Completed by	3 Suicide 6 Could not be 28e. Place 4 Homicide determined buil	ce of Injury - At home, farm, street ding, etc. (Specify)	factory, office	28f. Location (Street and Number City or Town, State)	er or Rural Route Number,
Division  To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification	(Check only 2 Medical Examiner: On the	basis of examination and/or inves	ccurred at the time, date and place, a tigation, in my opinion, death occurre	and due to the cause(s) and ma ad at the time, date and place, a	nner as stated. and due to the cause(s)
o tha lithin 2 o tha lomplet	one) and ma 29b. Signature and title of certifier	nner stated.	29c. License number	29d. Date signed	(Month, Day, Year)
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State Registrar	31. Date filed (Month, Pay, Year). 32. MAY 0 3 2005	gistrar's Signature	de 9		

	•	1 - Stata Registrar	State of Ma				e of Dea	ath		Reg. No.	400;	3. Time of D
siciai	n	1. Decedent's Name (First, Middle, L	ast)				Mas		Month Month	Day	ZOOK	9:25
edica		4a. Fecility Name (If not institution, gr	ive street and number)			4h City	Town, or Loca		April	40.0	county of Death	
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rol					last birthday)	If Under	1 Year If U	Inder 24 Hrs.	8. Date of Birti	h	9. Birth	nplace (State or F
ral tor		217-04-7474	1 X M 2 □ F	21	Yrs.	Months	Days Ho	ours Min.	(Month, Day	y, <i>Year)</i> 83		vintry) ry1and
		Usual Residence of Decedent										
		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City
	cto	MD NA			Balti	more						1 🕅 Yes 2
	Director	10e. Street and Number				10f. Zip					en of What Co	untry?
	ē	2712 W. North Avenue					21216			US		
	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		S. 13. V	Vas Deced Yes, spec	ent of Hispan of Cuban, Me	ic Origin? (S exican, Puert	pecify Yes or No- o Rican, etc.)	.   1	<ol> <li>Race - Amer Black, White</li> </ol>	
	by	1 X Never Married 2  Married 3  Widowed 4  Divorced	1 ☐ Yes 2 🔯 If Yes, Give Year or Dates:	No	1	Yes 2	No Sp	ecify:			Specify: D1 -	ala.
		15. Decedent's I			16a, Deced	lent's Usua	I Occupation			16b. Kin	Bla d of Business/l	
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	E	Elementary/Secondary (0-12)	College (1-4or	5+)		Ushe	r				Stadium	1
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	To B	Earl L. Moses					Dı	reamer I	. Pettawa	v		
	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address			ral Route Numbe		Town, State, Z	ip Code)
		Dreamer D. Pettaway/	/ Mother		2712 W	I. Nort	h Avenue	e Baltin	ore, MD 2	1216		
once.		20a. Method of Disposition		20b. P	lace of Dispos	sition (Narr	ne of		Date		ation - City or	Fown, State
5		1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec			ro Crema	•	ino piaco)	05-07	<b>'-</b> 05	Caton	sville,	MD
ei ei	-	21. Signature of Funeral Service Lice					d Address of	Facility				
ouce		1 min	and .	· ·	— Wy1	ie Fun	eral Hor	ne 638 N	. Gilmor S	St. Ba	lto, MD	21217
		23a. Part1. Enter the disease, or con shock, or heart failure. List on	mplications that caused	d the deat	h. Do not ente	er the mod	e of dying, su	ch as cardiac	or respiratory ar	rest,		Approximate Interval Between
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as									
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	Physician/Med	IF FEMALE:	23c. If yes, outcome	of progna								
	an	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fete	I death 3	Ectopic pr				23	3d. Date of deli Month	very Day Ye
3	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	9☐ Unknown	t thine or a	eath 5L	Other (sp	өспу)					
		Part II. Other significant conditions	contributing to death t	out not res	ulting in the ur	nderlying c	ause given in	Part I.	23e. Did to	bacco us	e contribute to	the cause of dea
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1	Completed								24a. Was autop	an sy med?	prior to death?	topsy findings av ompletion of cau
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1000	ို	1 Yes 2 To	28a. Date of Inju		ER/Outpatien 28b. Time of			☐ Nursing H	ome 5 Resid			ify)
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	ertification	3 Suicide 6 Could not 4 Homicide determine				o occurred	at the time de	ate and place	and due to the	cause/s) a	ind manner as	stated
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	Medical Certification	4 Homicide determine  29a. Certifier 1 Certifying F (Check only 2 Medical Ex.	aminer: On the basis of	of examina	wiedge, death tion and/or inv	vestigation.	in my opinior License nur				signed (Month	
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DHMH 17 Rev 1/2001

	-	State of Maryland / Dep 1- State Amend Item 28a per me G843 5-2-3	partment of Health and N Offic <b>ate</b> of Death	Mental Hygie	2005 14970
	4	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Physici		Alice B. McDonald		i .	Day Year 24 2005 1503 M
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		MEMORIAL HOSPITAL	CUMBERLAND	1	ALLEGANY
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	/) If Under 1 Year   If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
Director		212-24-1426 1□M 2XF 93 Yrs.	Montal's Day's Flours IMM.	May 21,1	911 Romney, WV
Pur &	-	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or 1	ocation		10d. Inside City Limits
laryla shor	20				1 XYes 2 □ No
the N	Director	WV Mineral Keyser  10e. Street and Number	10f. Zip Code	100	Citizen of What Country?
with		513 W. Piedmont Street	26726	log.	
.0036 hours after death with the Maryland hours of tems 23a or 28a-f show at Examiner must be notified at	Funeral		. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	USA 14. Race - American Indian,
fer d	표	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
Urs at	þ	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🔣 No Specify:		Specify: White
2 ho	Completed	15. Decedent's Education 16a. Dec	redent's Usual Occupation we kind of work done during most of work	161	b. Kind of Business/Industry
212 Prin 7	pie	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	King	
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nd sality doth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Mai	iden Sumame)
laryland 21215-0036 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "naturel; or items 23s or 28s-f show cumatic event, it a Modical Examiner must be notified at	ဥ	John C. Mayhew		ce V. Fout	
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altimore, rmit. Pages 1 ar epartment of Hee portent: if item y injury or othe		20a. Method of Disposition  1 ■ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition	rematory or other place)	pril 28	c. Location - City or Town, State
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e Ho. 24 h e Fur	edical	(Check only 2)   Medical Examines: On the basis of examination and/or	investigation in my eninion death easy.	erod at the time, date	and place, and due to the course(s)
To th within To th	Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, Day, Year)
1		humanforman, M.O.	D 56207	A	pril 25, 2005
h		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)		1 0
		HUSAM SEMAAN, M.D. Memorial	Hospital, Cu	mberlm	d MI) 21502
St	ate	31. Date filed (Month, Day, Year) 32. Registrar Signature	4 South		
Regist	rar	29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Typ HUSAM SEMAAN, M.)  31. Date filed (Month, Day, Year)  32. Registrar Signature  MAY 0 3 200	1 Photo		

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	Physicia /Medic		Mar	y Jear	nne M	Marku	son				APRIL	29	2005	0131 A <sup>M</sup>	
	Examin		4a. Facility Name (If not institution,	give street and num	nber)		4b. City,	Town, or	r Location o	of Death		4c. Cou	nty of Death		
			GREATER BALT					TOWS					IMORE		
	Funeral			6. Sex 1 □ M 2 🔯 F	7. Age (In yrs. las		If Under Months		If Under	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign intry)	
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	and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation							10d. Inside City Limits	-
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0	ding Ph J. After th funeral		27. Manner of Death	28a. D te c	of Injury h, Day Year)	8b. Time o	of 2	8c. Injury Work	y at		28d. Describe he	ow injury occ	curred		
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<u>×</u>	r Atta er deg racto	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place	of Injury - At homing, etc. (Specify)	e, farm, st	reet, factory	, office			28f. Location (Si City or Town	reet and Nu	mber or Rui	ral Route Number,	-
	spital or Al ours after o														
	To tha Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death.  To tha Funaral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	(Check only 2 Medical t	g Physician: To the Exeminer: On the ba	isis of examination	edge, deat n and/or in	th occurred a	at the tim	ne, date an oinion, dea	id place, th occuri	and due to the c	ause(s) and ate and olac	manner as	stated. to the cause(s)	
	To tha Hos within 24 h To tha Fur completely	Med	One)	and mann	er stated.										
	S J S S		29b. Signature and title of certifier	1				^	e number	7).		9d. Date sig	/ /		
	11/		GIV					J	277	50		7/4	4101		
			30. Name an address of person v		e of death (Item 2	3a) (Type,	Print)		7 1	~	AL	771-	25	41 21204	
			31. Date filed (Month, Day, Year)	32. Re	trar's Signatur	N.	411	The contract of the contract o		( -	00/6	1 (7)	10/	1/	_
	Sta Registi		MAY	2 3 2005	trar's Signatur	D.	7								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month MAY 2,2005 11:05 a<sup>M</sup> **Physician** LORETTA MERTEL Μ. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A BALTIMORE 8. Date of Birth (Month, Day, Year) FUTURE CARE CANTON HARBOR If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Min. **Funeral** Days Hours 1 ☐ M 2 XF MARYLAND 83 218-44-1978 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a, State in then "naturel", or iteme 23a or 28a-f show the Medical Examinat must be notified at Yes 2□No BALTIMORE N/A Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 U.S.A. 243 S. BOULDIN STREET Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2√ No If Yes, Give 11. Marital Status Black White etc. 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: Maryland 21215-0036 WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education 72 (Specify only highest grade completed) d 2 should be filed within th and Mental Hygiene. 7 Is marked other then ' College (1-4or 5+) Elementary/Secondary (0-12) HEALTH CARE NURSE 3 18. Mother's Name (First, Middle, Maiden Sumame) other traumatic event, 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be MERTEL MARGARET **FUCHS** GEORGE G. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 243 S. BOULDIN STREET, BALTIMORE, MD. 21224 item 27 l GEORGE MERTEL/HUSBAND Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition i = 10 1 Burial 2 Cremation 3 Removal from State Department of Importent: If any injury or once. SACRED HEART OF JESUS 5/6/05 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee LILLY & ZEILER INC. FUNERAL HOME 21224 Charles Control CONKLING STREET, BALTIMORE, MD. 700 S. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) A hvillation **Physician** /Medical Due to (or as a consequence of): Examiner per teneia Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (At as a consequence of): Examiner ementic or Attending Physicien: The faw requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Box 68760, teast Valves Physician/Medical use as the IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 5 Other (specify) 4 Pregnant at time of death detached 9 Unknown o signed by Division of Vital Records, P. 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No has 1 ☐ Yes 2 ☐ No 1 Yes certificate 26. Place of Death Check on one 25. Was case referred to medical Be Other: Hospital: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient Certification: To this 28b. Time of within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cegifier 5/2 105 DO055171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eastern Huc 3023 SEBASTION 31. Date filed (Month State 2005 0 Registrar

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Į.	Examin	er	4a. Facility Name (If not institution, give si		1.	City, Town, or Location		/-	4c. County of De	eath
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	pue A		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Location		- /			10d. Inside City Limits
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	n the	Director	10e. Street and Number	2		. Zip Code		10g.	Citizen of What	Country?
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	er de de de de de de de de de de de de de	Funerai	The state of the s	<ol> <li>Was Decedent Ever in U.S Armed Forces?</li> <li>1 ☐ Yes 2 ☑ No</li> </ol>		ecedent of Hispanic specify Cuban, Mexi	Origin? (Speci ican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.
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altimore,	permit. Pages 1 a Department of Hee Important: If ttem any injury or othe once.		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>		FY FIEL 22 Nam	e/and Address of Fa	acility 200	CO 0 11:	HIO.	70.
ñ	Depart Depart Import any inj		I homes J. x	Kardo h	SK	AKDA FI	4 3	ALTO	MD.	1224
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68760	ate the	edical	d.							
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	oital o urs aft aral Di									
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical	29a. Certifier 15 Certifying Physic (Check only one) 2 Medical Examin	cian: To the best of my know er: On the basis of examinati and manner stated.	vledge, death occu ion and/or investiga	rred at the time, date ition, in my opinion, d	and place, and death occurred	d due to the cause at the time, date a	(s) and manner and place, and d	as stated. ue to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. License number			Date signed (Mo	
			Manusho &	Sahl, MI	>	D005	8913	APF	(1L 2)	2005
	1		30. Name and address of person who cor	npleted cause of death (Item	23a) (Type, Print)	5601 L	CL4	RAVEN	1 30	ULEVARD
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	,011110 1		1 _ State	State of Maryland /		artment of Health and I rtificate of Death	mental Hy	6000	14974
	_		Registrer  1. Decedent's Name (First, Middle, Last)			uncate of Death	2. Date of D	Reg. No.	3. Time of Death
	Physici		GARY CURTIS N	ICKENS			Month APRIL	27,2005	
	/Medic Examir		4a. Facility Name (If not institution, give s			4b. City, Town, or Location of Deat		4c. County of D	
1			PRINCE GEORGES HOS	PITAL COUNTY		CHEVERLY		PRINCE (	GEORGES
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last I	,,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bi	rth a I	Birthplace (State or Foreign Country)
	Director		136-68-0661 Usual Residence of Decedent	27	Yrs.			-1978	NJ
	/land		10a. State 10b. County	10c. City, To	wn or Lo	cation			10d. Inside City Limits
	Man B-f sh	ģ	DC	WAS	HING	TON			1X Yes 2 □ No
	th the	lrec	10e. Street and Number	WILL	11111	10f. Zip Code		10g. Citizen of What	Country?
	72 hours after death with the Maryland natural", or tems 23a or 28a-1 show lical Examination indition at	by Funeral Director	4336 GORMAN TERRA	CE SE		20019		USA	
	er dez	nue		<ol><li>Was Decedent Ever in U.S. Armed Forces?</li></ol>	13.	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puert	pecify Yes or No o Rican, etc.)	0- 14. Race - A Black, W	mencan Indian, hite. etc.
36	rs afte	y F	1 ☐ Never Married 2 ※ Married 3 ☐ Widowed 4 ☐ Divorced	1		1 ☐ Yes 2🌠 No <i>Specify:</i>		Specify:	
5-0036	2 hou		15. Decedent's Educ	ation 16	a. Dece	dent's Usual Occupation		16b. Kind of Busine	SLACK ss/Industry
215	within 72 ene. than na	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done during most of wor DO NOT use retired)	rking	iss. Italia of Basilis	3 moustry
21	filed with Hygiene. Ither thai	Completed	12	30.10g5 (1 401 01)	DE	LIVERYMAN		DPI MIDA	TLANTIC
Maryland	be file	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle	, Maiden Surname)	
∑,	should be nd Mental marked c	2	GARY CURTIS SMITH					NE NICKENS	
Mai	nd 2 sho alth and 27 Is m		19a. Informant's Name/Relationship (Type CHRISTIAN NICKENS/			og Address (Street and Number or Ru GORMAN TERRACE,			a, Zip Code) 20019
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exam and must be codified at		20a. Method of Disposition	20b. Place	of Dispo	sition (Name of	Date WASI	20c. Location - City	
altimore,	eg t ≠ 7		1 Burial 2 ☐ Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)	movariiom State		natory or other place) IN CEMETERY			
ij	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License			11111	3,2005 AMES A.		EW JERSEY ONS F.H., INC
ä	permi Depa Impo any ir	4 1	James 9-	morton	1	701-31 LAURENS ST			YLAND 21217
			23a. Pag. Enter the disease, or complice shirck, or heart failure. List only on	ations that caused the death. De	o not ent	er the mode of dying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Mult	154	e (runshot l	Nous	ds	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	e in:	g - Grot			
	_xammer	e	Sequentially list conditions, b.	Due to (or as a consequence	o odle				
	nsit		cause. Enter Underlying Cause (Disease or injury	The to go as a consequence	a cay				
Ć.	executed n and ial-transi	Examin	that initiated events c. resulting in death) Last	Due to (or as a consequence	e of):				
9289	ficate be e physiciar s the buri	cal	d						
	ntifica ng ph as th	Medi	IF FEMALE.				700		
Вох	leath certifica attending ph for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	<ul> <li>c. If yes, outcome of pregnancy</li> <li>1 ☐ Live birth 2 ☐ Fetal dea</li> </ul>	th 3□	Ectopic pregnancy		23d. Date of d	,
0.	the a	ysic	1 Yes 2 No	4□Pregnant at time of death 9□Unknown	5□	Other (specify)		Month	Day Year
<u>α</u>	The law requires that the death certificate be tte has been signed by the attending physicis bage 2 should be detached for use as the bu		Part II. Other significant conditions conf	ributing to death but not resulting	in the ur	iderlying cause given in Part I.	23e. Did t	obacco use contribute	to the cause of death?
ecords,	uires sign ld be	d by				, , ,	1 🗆 '	A.C	Probably 4 □Unknown
Ö	w requ	Completed					24a. Was	an 24h Were	autopsy findings available
$\alpha$	The lav	dmo					autor	prior to death?	completion of cause of
Vital		O	25. Was case referred to medical			26. Place of Dea		- /	es 2 No
of V	d is	To B	examiner? 1 ☑ Yes 2 ☐ No	spital: 1 ☐ Inpatient 3(XER/C	Outpatien	Other		dence 6 □Other (Sp	pecify)
		on:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. ate of Injury (Month, D. Year)	. Time of Injury	28c. Injury at Work?	28d. Describe I	how injury occurred	1
Division	ten feat tor: the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	4/26/05/2	520	M 1 □ Yes 2 No	Subj	ect she	20_
Div	i Diffe	ertif	Hornicide determined	28e Place of Mury - At home, building, etc. (Specify)	farm, stre	eet, factory, office	City or To	Street and Number or I vn, State)	Rural Route Number,
_	pital		29a. Certifier 1 ☐ Certifying Physi	cien: To the best of my knowledge	e, death	occurred at the time, date and place,	and due to the	Causals) and manner	14 landsier
	To the Hos within 24 hd To the Fun completely	edical	(Check only one) 2. Medical Exemin	or: On the basis of examination a and manner stated.	ind/or inv	estigation, in my opinion, death occur	red at the time,	date and place, and di	ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	$\wedge$		29c. License number		29d. Date signed (Mor	nth, Day, Year)
)	~		1/ Josh	me		O.C.M.E		APRIL 27	, 2005

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 PENN STREET, BALTIMORE, MARYLAND 21201

31. Date filed (Month, Day, Year)

MAY 0 3 2005

			1- State of Maryland / Department of Healt Certificate of Dea		nıaı myglen Rea. N	2015	14975
	Physicia	an	1. Decedent's Name (First, Middle, Last)  DOROTHY  R. NOION	2		ay Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Locat	ation of Death	MAY 4	c. County of Dear	
			Saint Joseph Medical Center	Towso			timore
Ĺ	Funeral Director		215-30-5751 10 M 210F 7/ Yrs. Months Days Hou	Inder 24 Hrs. 8 ours Min.	3. Date of Birth (Month, Day, Yea 10 -27-3	9. Bir	hplace (State or Foreign puntry) ARYLAND
	yland now		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		•		10d. Inside City Limits
	Ba-f st	Director	MD BALTIMORE Cockeysvi	ille			1 ☐ Yes 2 No
	death with the Maryland ms 23e or 28a-f show	급	10e. Street and Number 10f. Zip Code 210	030	10g. C	itizen of What Co	ountry?
	death	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  13. Was Decedent of Hispanic If Yes specify Curan Mey		ify Yes or No-	14. Race - Ame Black, Whit	rican Indian,
0000	iges 1 and 2 should be filed within 72 hours after death with the Marylan in of Health and Mental Hygiene.  If item 27 is marked other than "neturel", or Items 23e or 28e-1 show if item 27 is marked other than "neturel", or Items and Items in of items or other treumatic event, Items was great that the marked at	þ	1 Never Married 2 Married 1 Tes 2 MNo	ecify:	carr, etc.)	Specify: W	
ָה ה	n 72 h	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired)	nost of working	16b.	Kind of Business	Industry
7 7	filed within 72 Hygiene. other than "nel	dmo	Elementary/Secondary (0-12) College (1-4or 5+)		ou	in home	_O
and	be file tal Hyg d othe event,	Be		Mother's Name (	First, Middle, Maide	n Sumame)	t
719	should and Men Is marke	70	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and No.	lumber or Bural F	C. COCA	or Town State	in Code)
N N	alth ar alth ar 27 is		Joseph Rolan 911 Cotes axxx	Circle	Cockes	15 V. 11e	MN 21030
ore e	Pages 1 and the north of the north of the north of the north or other north orth orth orth orth orth orth orth		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)	Dat	200	ocation - City or	Town, State
baitimor	t. Part rtant rtant		4 Donation 5 Other (Specify)	5-5	-05 Ti	nonium	ma
n	permi Depa Impo any is		21. Signature of Funeral Service Licensee  22. Name and Address of F 23 25 YO RIG PEACEFUL ALTO	CRD.,T	IMODION	PAI CH	21093 APEI
ı	,tr		23a. Part 1. Enter the disease or complications that saused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line			200	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final graph of the condition as PROGRESSIVE METASTATIC : PROGRESSIVE METASTATIC :	BREAST	CANCER		Onset and Death
	Examiner		Due to (or as a consequence of):  Sequentially list conditions.				
/	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
Ď	an and	Exal	that initiated events c.  resulting in death) Last  Due to (or as a consequence of):				
08/00	tificate be executed g physician and as the burial-transit	edical	d				
o XOD	eath certificate be executed attending physician and for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of del	iverv
ğ	D 0 D	hysiclan/N	in the past 12 months?  1  Yes 2 No			Month	Day Year
٦ ر	that the	۵	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P	Part I	23e. Did tobacco	use contribute to	the cause of death?
ecords,	w requires that the s been signed by th should be detache	leted by			1 Tes	1924	obably 4 Unknown
zec Zec	e law has b	omple			24a. Was an autopsy	24b. Were au prior to death?	topsy findings available completion of cause of
VIII	iician: The certificate his rector, page	e C	25. Was case referred to medical 26. F	Place of Death (0	performed?  1 Yes 2 N	o 1 ☐ Yes	250 No
01 VI	Physician: this certific ral director,	To B	examiner:		5 Residence	6 □Other (Spe	cify)
SION	ding After fune	tlon:	27. Manner of Death 1 Manual 5 □ Pending (Month, Day Year)   28b. Time of   28c. Injury at Work? 2 □ Accident investigation   M   M   1 □ Yes		d. Describe how inj	ury occurred	
NSIN	l or Attending after death. Director: After I in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		f. Location (Street a		ıral Route Number,
<u>&gt;</u>	itel or irs afte rel Dir		and the state of t		City or Town, Sta		
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, dat 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, and manner stated.	ate and place, and n, death occurred	d due to the cause( at the time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To with To t	Σ	29b. Signature and title of certifier 29c. License numb		29d. D	ate signed (Monti	
•	()		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0	177	ey 157,	2000
	70		TOGINDER D. MEHTO M.D. 7601 DOLER DR.	IVE. TO	DWSON. N	IARYLAN	D 21204
	Sta Registr		31. Date filed (Month Ayr 0") 3 2005 32. Segistrar's Signature	,	,		

State of Maryland / Department of Health and Mental Hygiene 14976 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year MARIAN WILLSON 1, OTTINGER 2005 May 7:00AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Uak Crest Care Center Baltimore, Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Year)

Months Days Hours Min. (Month, Day) Year)

Lecember 28, 1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X 220-07-3544 85 Yrs Director Unio Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event. The Medical Event har must be rivilified at 1 □ Yes 2 □ No Completed by Funeral Director Marviand Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd 21234 USA 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes XX No WHITE Specify Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be finance and Mental File marked of Thomas John Willson Hazel Ada MacCallum ဥ Je, Mt.
Jermit. Pages 1 and 2 sho.
Department of Health and M.
Important: If I fem 27
any injury or 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marc W Ottinger Son 7004 Wellington Ct Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State ureenMount Cemetery 5/2/05 □Donation 5 □ Other (Specify) Baltimore Maryland 1/Signature of Funeral Ser 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULAR ACCIDENT **Physician** days disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ - Vascular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? perform sderosis multiple 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending after death. Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 25643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 Walther Blud Kendale Rfaulkner MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Barry Eugene Peeler Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-03002 State of Maryland / Department of Health and Mental Hygiepen crn Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** Barry Eugene Peeler April 30 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Franklin Square Hospital Rosedale Baltimore 6. Sex 1 X M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, July 23 Birthplace (State or Foreign Country) **Funeral** Year) 63 243-62-1718 Director Yrs. 1941 N. Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "naturel", or Items 23a or 28a-1 show the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Baltimore Baltimore. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8535 Gradien Drive 21236 u.s.A. filed within 72 hours after death the Hygiene. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade Carpenter General Construction other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fit treet of Health and Mental Hient: If Item 27 is marked off lury or other treumatic even Be Arthur Wilson Peeler Clara Plummer L. 19a. Informant's Name/Relationship (Type, Print) (sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8535 Gradien Drive, Baltimore, MD 21236 Mrs. Barbara Anne Basham 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Department of Importent: If any injury or once. Bayview Crematory 5/03/2005 \* 4 ☐ Donation 7 5 ☐ Other (Specify) Baltimore, Maryland he levie Licensee 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature 9705 Belair Rd., Baltimore, MD 21236 Approximate Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusito (or as a consequence of): Examiner sician and e burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical attending phys I for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 34 Probably 1 ☐ Yes 2 ☐ No 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 \( \subseteq No prior to c death? 1 Yes Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner?
1 ♣ Yes 2 ☐ No Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ER/Outpatient 2 1 Inpatient З□ DOA 28a. Date of Injury (Month, Day Year) Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural s after decreased Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie and manner stated. 29b. Signaty e and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Manufic

2005 Registrar's Signature

empleted cause of death (Item 23a) (Type, Print)

111 Penn Street Baltimore Maryland 21201

OCME

May 01, 2005

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiefien For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 2005 Thomas Edgar Perry 29, 5:20 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3849 Memory Lane Apt.C Abingdon Harford 8. Date of Birth (Month, Day, Year) Sept. 10, 1 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1⊠M 2□F 75 Yrs. 220-20-1387 Sept. Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Harford Abingdon 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3849 Memory Lane Apt.C 21009 USA 12. Was Decedent Ever in U.S.
Amed Forces?

1Xi Yes 2 □ No 194
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1947 1 Never Married 2 Married 1950 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas W. Perry Irene Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Perry, Daughter 2007 Magnolia Woods Ct. UnitD Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory Inc. 05/02/05 \* 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland <sup>22 Name and Address of Facility</sup> Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Vicensee Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mocardial infection disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2□ No 25. Was case referred to medical 26. Place of Death Check on one examiner? Dther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗶 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of

Paysician /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

Directo

Completed by Funeral

Be 2

**Funeral** 

**Director** 

28e-f show

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Ітать 23а

Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. snt: If Itam 271s markad othar than "natural", or Itams 23.

Baltimore, Maryland 21215-0036

traumatic event, the Medical Examiner must be notified at

other

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Department of Important: If any Injury or once.

with the Maryland

The law requires that the death certificate be executed use as the burial-transit for detached à pe page 2 should Hospitel or Attending Physician:

P.O. Box 68760,

Division of Vital Records,

funeral director, after death.

Examiner Physician/Medical ģ Be Completed Certification: To filled in by Medical completely

2 T Accident 3 ☐ Suicide 4 T Homicide 29a. Certifier

1 ANatural

(Check only one)

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Belair, MD

29b. Signature and title of certifier S. Paquray. mb

5 Pending

investigation

6 Could not be determined

29c. License number D 53720

Po

# 100

29d. Date signed (Month, Day, Year) 05(02/2005.

21044-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pagaraj. mp 602, S. Aturood

2005



State Registrar

24 hours a Funaral C

within 2 To tha I the

Charles E. Reichard 05-02933 crn

			For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of H rtificate of L		lental Hygie	211115	14979
	Physici		1. Decedent's Name (First, Middle, La Charles E. Rei	,				2. Date of Death Month ADCIL	27 26	3. Time of Death 7:15 P M
>	*/Medio Examir		4a. Fecility Name (If not institution, gir	e street and number,	)		Location of Death	J	4c. County of D	Death
			10078 Vista Cou		ge (In yrs. last birthday)	Myers	Ville If Under 24 Hrs.	9. Date of Birth		lerick
	Funeral Director		-	1⊠M 2□F	78 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye May 17,	1926 M	Birthplace (State or Foreign Country) aryland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	a Mary ta-f sh riffed	ctor	MD Frederi	ck	Myers	ville				1 ☐ Yes 2 🙀 No
	h with the Maryland 13e or 28e-f show 11 be nailfied at	Funeral Director	10e. Street and Number 10078 Vista Co	ourt		10f. Zip Code 217	73	10g.	Citizen of Wha	t Country?
920	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-1 show any lojury or other traumetic avent. It a Medical Examinar must be pullind at any lojury or other traumetic avent. It a Medical Examinar must be pullind at angles.	þ	11. Marital Status  1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 X Yes 2 ☐ If Yes, Give Year or Dates:	No	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 ☒ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, V Specify:	American Indian, Vhite, etc. White
21215-0036	n 72 ho	Be Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a, Dece	dent's Usual Occupa kind of work done d DO NOT use retired)	ition uring most of work	ing 16t	o. Kind of Busine	ess/Industry
212	d within giene. ar than	omo	Elementary/Secondary (0-12)	College (1-4or	5+)	trical me			eating .	and air cond
and	l ba file ntal Hy Bd othe BvBnt.	Be C	17. Father's Name (First, Middle, Las. John Rowland Re					e (First, Middle, Mai	den Sumame)	
Maryland	should and Me s mark umatic	၉	19a. Informant's Name/Relationship		19b. Mailie			hryn Mart al Route Number, C		re, Zip Code)
	tealth and 27 lbm 27 lbm tra		Steven R. Reicha	rd/son		Dual Pla			21740	_
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Importants: If item 27 is marked other than any fujury or other traumatic avent. If a M. Once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☑ Donation 5 ☐ Other (Speci	fy)	20b. Place of Dispo cemetery, crei	natory or other place	)	Date 20d	c. Location - City	or Town, State
Balt	permit. Depart Import any Inj		21. Signature of Funeral Service Lice	Wade, Dir	Total 22	2. Name and Address State Anam Baltimore	s of Facility Lomy Boar MD 212	655 W.	Baltimo	re Street
	Physician /Medical		23a. Partil. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Z Lei	d the death. Do not ent ine. A cutture a consequence of):	er the mode of dying	, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Examiner	J.	Sequentially list conditions,	b	a consequence of):					
	nd transit	amin	rany, leading to annieulate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
68760,	icate be axecuted physician and s the burial-transit	edical Examiner	resulting in death) Last	Due to (or as	a consequence of):					
.O. Box 68	ath certif ttending or usa as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
Δ.	quires that the de n signad by the a uld be detached f	by	Part II. Other significant conditions	contributing to death b	out not resulting in the u	nderlying cause give	n in Part I.			e to the cause of death?  Probably 4 Unknown
Il Records,	The ata his page	Completed						24a. Was an autopsy performed 1 ☐ Yes 2 △	prior death	autopsy findings available to completion of cause of 1?
Vital	Physician: The this certificata h: ral director, page	o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatien	t 3 DOA Other	_	n <i>(Check only one)</i> me 5 ☐ Residence	Str. Other (6	
Division of	ding Ph n. After th funeral	Certification; T	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigatio 3 ☒ Suicide 6 □ Could not be	28a. Date of Inju (Month, Da FOULD	irv 28h Time of	28c. Injury Work	at ? es 2 ∰No	28d. Describe how in	njury occurred	autod
Divi	in Direction		4 Homicide determined	building, et	iury - At home, farm, str tc. (Specify)	re		Myers vill	tate) 10078 2, MD 2	1773 Fullwick Co.
	To the Hospital within 24 hours a To the Funaral I completely filled	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Pl 2 ☐ Medical Exam	nysician: To the best niner: On the basis o and manner st	of my knowledge, death of examination and/or invaled.	n occurred at the time restigation, in my opi	e, date and place, inion, death occurr	and due to the cause ed at the time, date	e(s) and manner and place, and	as stated. due to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifler	1 -	Ma	29c. License			Date signed (M	
7		9	30. Name and address of person who	completed chuse of o	death (Item 23a) (Type,		C.M.E.	Ap	ril 28,	2005
	10-0		S.P.HOX	MAN	111		eet, Bal	timore, M	aryland	21201
	Sta Registr	- 25	31. Date filed MAY 0, 3 200	5 32. Registr	ar's Signature	E				

JET 05-02<u>9</u>96

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

0, Baltimore, Maryland 21215-0036	Pny /N Exa	an and Both I from the standard of the standar
Division of Vital Records, P.O. Box 68760,	To the Hospitel or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.	remains a state of the following the state of the state o

	Gary F	. Ł	Rohrs 1 - State Registrar	State of Maryland					Mental Hy	/giene	005	149	80
			Registrar  1. Decedent's Name (First, Middle, Las	(t)	Cei	тітіса	te of Dea	itn	2. Date of D	Reg. No.		3. Time o	f Dooth
	Physici		Ganif	Robes					April	Day	2005 Year		р <sup>М</sup>
>	/Medio Examir		4a. Facility Name (If not institution, give	street and number)		4b. Cit	, Town, or Locat	tion of Death	<del></del>		County of Death	1:18	Р.
п			1 Cypress Drive			Mid	dle Rive	2r		Ba	ltimore		
	Funeral		5. Social Security Number 6. S	9x 7. Age (In yrs. la ☑M 2□F	. ~		er 1 Year If Ur	nder 24 Hrs.	8. Date of B.	irth	9. Birth	place (State	or Foreign
	Director		Usual Residence of Decedent	3	3 Yrs.				8-6	-51	MAN	ZYLAN	10
	ylend yow		10a. State 10b. County	10c. City	, Town or Lo	cation						10d. Inside C	ity Limits
	e-fet	ctor	MD Ballie	nore	Mi	ddl	e Kiv	eR				1 🗌 Yes	2 No
	or 28	Dire	10e. Street and Number			10f. Z	ip Code	2.1		10g. Citiz	zen of What Cou	ntry?	
	a 23a	rai	10 Cypress 1	SRIVE.			2120				USA		
	itam Itam	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 124 Yes 2 ☐ No	5.   13.	Was Dec f Yes, sp	edent of Hispanic ecify Cuban, Mex	c Origin? (Sp xican, Puerto	ecify Yes or N Rican, etc.)	0- 1	<ol> <li>Race - Ameri Black, White,</li> </ol>	can Indian, etc.	
936	urs al	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 No Spe	cify:			Specify: W	hite.	
Maryland 21215-0036	ould be filed within 72 hours after death with the Marylend Mental Hygiene. arked other than "neturel", or liama 23a or 28e-f ehow atto evant, the Mydical Exambra must be redillied at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Deced	dent's Us	ual Occupation onk done during	most of work	rina	16b. Kir	nd of Business/Ir	ndustry	
121	within ne. han *	mpj	Elementary/Secondary (0-12)	College (1-4or 5+)	O life.	CONOT	use retired)		9	1. 1. 1	Tair	i	Carr
i D	filed v Hygie thar t	ပိ	17. Father's Name (First, Middle, Last)		Velt	eny	Diayed	Inther's Nam	e (First, Middle		er I Rea	TIMEAT	yec
an	ld be ental ked o	To Be	Anthony A.	Rohrs				21000	S Par	+71	n İ		
ary	S D E E	-	19a. Informant's Nam elationship (7		19b. Mailir	Addres	ss (Street and Nu	imber or Run	al Route Numb	per, City or	Town, State, Zij	o Code)	
	and 2 ealth a n 27 Is		Mancy ( Hutt	man	309	Sisa	rta G	Bel	Air. 1	ID .	21014.		
altimore,	jes 1 of He If itan		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □	Removal from State	ace of Dispo metery, cren				Date		cation - City or T		
Ē	tment of trant: If it		* 4 ☐ Donation 5 ☐ Other (Specify	Evai	15 FUN	eral	Chapol- ind Ad ress of F	5-2	-05	Fore	est Hil	I, MC	7
Bal	permit. Departr Importa any inju		21. Signature of Funeral Service Licen	20 Liter	22	. Name a	ind Ad ress of F	acility BAC	TIMORE,	MD	21234		
			23a. Part1. Enter the disease or comp	plications that caused the death.	Do not ent	andS er the mo	FUNDER	as cardiac	PGC , SS	CO 117	ARFORL	Approximat	Θ.
	Secretary.		Immediate Cause (Final	one/daus on ach line.	14=	(	م م در ا	- 0	- 0.0			Interval Bet Onset and	ween
	/Medical		disease or condition resulting in death)	aDue to (or as a conseque	ence of):	9	ALE MA	war	V 3 (	age	-		
	Examiner		Sequentially list conditions,	b									
	p is	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):								
_	xecute and II-tran	xam	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseque	ence of):								
58760,	cate be executed physicien and the burial-transit		l	4									
_		ledicai		u									
Box	death certifical attending place as t	Physician/M	200. Was decedent program	23c. If yes, outcome of pregnan 1☐Live birth 2☐Fetal o		lEctopic i	pregnancy			2:	3d. Date of delive	•	
о. П	at the dea by the at stached fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of dea 9☐Unknown		Other (s					Month	Day A	/ear
٥.	The law requires that the death certif sie has been signed by the attending page 2 should be detached for use a	Phy	Part II. Other significant conditions of	ontributing to death but not resul	ting in the ur	nderlying	cause given in P	art I	23e Did	tohacco us	se contribute to t	he cause of d	leath?
Records,	uires that signed b	d by	Choric M	obstism		ra arry in g	oddoo givoir ii r	u11 1.		Yes 2□	-	ably 4 □l	
CO	w require s been si should b	iete	Drobetes	Neslitue					24a. Was	an	24b. Were auto	psy findings	available
	The law	Completed	710 7010	,. <u>_                                   </u>					auto perfe	psy prmed2	prior to co death?	mpletion of c	ause of
Division of Vital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. P	lace of Death	1 ☐ Yes	2 No	1 ☐ Yes	2 110	
<u>&gt;</u>	Physician: this certificatal director, p	2	1X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ E		-	OA Other: 4	Nursing Ho	me 5 ☐ Resi	dence 6	Tother (Specif	Scene	
n c	ding P h. After t funera	inol .	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Work?		28d. Describe	how injury	occurred		
S	ttand death ctor: ,	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hon	ne form etre	M facto	1 Yes 2		28f Location /	Strant and	Number or Rum	J Courte Misses	hav
<u>&gt;</u>	after after Direct	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	10, 141111, 3116	ot, lacto	y, office		City or To	wn, State)	TABINDE OF FIBE	ii noule ivaiii	uer,
	To the Hospitel or Attanding Physician: within 42 hours after death and 170 tha Funaral Director After this certifies completely filled in by the funeral director, p		29a. Certifier 1 Certifying Ph	/sicien: To the best of my know	ledge, death	occurred	at the time, date	and place,	and due to the	cause(s) a	and manner as s	tated.	
	he Ho in 24 ha Fu	Medical	(Check only one) 2 Medical Exem	iner: On the basis of examination and manner stated.	on and/or inv	estigatio	n, in my opinion,	death occurr	ed at the time,	date and p	place, and due to	the cause(s	)
	To t	Σ	29b. Signature and title of certifier			29	c. License numb	ner ne		29d. Date	signed (Month,	Day, Year)	
	1.1		John	W)			OCME			Mav 1	2005		
	1141		30. Name and address of person who c	completed cause of death (Item :	23a) (Type, I	2rint) 111	l Penn S	treet	Baltim	ore M	Maryland	21201	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ıre						,		
	Registr		MAYOR	2005	4		9 -						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HUK Ba HMO rear If Under 24 MLTIMORE 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 27 Ia markad othar than "natural", or Itams 23a or 28a-f shov traumatic evant, the Medical Exercities must be redified at 1 ☐ Yes 2 No Director more 10g. Citizen of What Country? Funeral Was Decedent of Hisp If Yes, specify Curan, 14. Race - American Indian, Black, White, etc. 11. Marital Status Forces? Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 Is markad othar than "natural", or Itel 2 Married 1 Never Married 1 ☐ Yes Baltimore, Maryland 21215-0036 Specify: White 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Union Lron 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 Is any injury or othar train once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🗆 Burial 2 🔯 remation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Funeral Ferral Ligensee of 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician a hed for use as the burial-i Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à dis wmonary 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: After this certification funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 2/No Other: 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in bushed. 1 ☐ Yes 2 ☐ No hours after death. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towson 1312 TUN joucher -M. egistrar's Signature

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 4:52am M Ruth Ileen Rush 30, 2005 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. September 27, 1918 Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√□ F 214-01-8046 86 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits in marked other than "natural", or Itams 23a or 28a-f show traumatic event, It e Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director MD Baltimore Phoenix 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 14417 Jarrettsville Pike permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Menlal Hygiene. Important: If item 27 is merked other than "natural, or Itams 23a any injury or other traumatic event, It a Madical Experimentance. 21131 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: ۵ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Exectutive Secretary Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Saum Marriott Greninger ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14417 Jarrettsville Pike, Phoenix, MD Cynthia G. Jacobson-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 5/2/05 Towson, MD 14 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 Yark Rd., Tausan, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** botho /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-fransit or Attending Physician: The law requires that the death certificate be executed ec that initiated events resulting in death) Last Due to (or as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 X Unknown Month Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ nctive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificafe 2 No 1 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Marinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No /s after deam. /ral Director; After this / Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0025758 301 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6569 N. Charles St. M.D. 32. Figistrar's Signatur 31. Date filed (Month, Day, Year) State MAY 0 3 2005 Registrar

		1- For Amend Item 21 State of Maryland / Dep Per FH, C843, 05/03	artment of Health and Menta /05dhb Inflicate of Death	al Hygiene 005 14983
		1. Decedent's Name (First, Middle, Last)		te of Death 3. Time of Death
Physi		Comment	Solver S Mo	onth Day Year
/Med		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Exam	iner		D. Sily, Town, of Education of Beauty	
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.   8 Dat	te of Birth  9. Birthplace (State or Foreign
Funera Directo		10M 25F	Months Days Hours Min. (Mo	onth, Day, Year) Country)
Directo		219-16-8407		07/1916 MD
and		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
hary sho	ក	MD Baltimore Dumdal	l1_	1 ☐ Yes 2 📆 No
he N	Director	MD Baltimore Dunda1		
with vith learn	ä		10f. Zip Code	10g. Citizen of What Country?
5-0036 72 hours after death with the Maryland "neture!", or Items 23a or 28a-f show offest Examilines at	2	2107 Cameron Drive Apt 1B	21222	USA
te m	Funeral	Armed Forces?	<ul> <li>Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, or</li> </ul>	es or No- etc.) 14. Race - American Indian, Black, White, etc.
36 safte	by Fi	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes X No Specify:	
21215-0036 ad within 72 hours aff glene. or than "neturel", or it, it e M. sifed Exert	d b	3 Widowed 4 Divorced Year or Dates:	4	Specify: White
21215-0 1 within 72 ho piene. r than "netu	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation  e kind of work done during most of working	16b. Kind of Business/Industry
within within ene.	l dr	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	
a filed w I Hygie other to	S	U years	sewife	Own Home
<u> </u>	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First,	Middle, Maiden Sumame)
arylar should be and Menta e marked	ျ	Jan Myslinski	Stanislawa	Moniewska
Maryland d 2 should be file th and Mental Hy ti e marked oth traumatic event		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ing Address (Street and Number or Rural Route	
		Celeste M. Ogden, Daughter 4039	Sharilyn Drive, Abin	edon. MD 21009
Baltimore, permit. Pages 1 ar Department of Heal mportant: If item		20a. Method of Disposition 20b. Place of Disposition	osition (Name of omatory or other place)  04/20/20	
Pages nent of unt: if its			leart of Jesus Cem	
Hir Purity Indian			22. Name and Address of Facility	Dundalk, MD
Baltimo			onnelly Funeral Home	of Dundalk P.A
		200 Bart State discount live in the same B	connelly Funeral Home (110 Sollers Point Road	d, Dundalk,MD 21222
	.;	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respire	Interval Between
Fnysician		Immediate Cause (Final disease or condition resulting in death)	ILL CP	Onset and Death
/Medica		resulting in death)  Due to (or as a consequence of):		que s
Examine		Sequentially list conditions b. Caronary	Heart Dispose	1100.00
	je 📕	Sequentially list conditions, It any leading to immediate Cause. Enter Underlying	13131131	41.03
uted d ansil	Examine	Cause (Disease or injury that initiated events		
), exec n an ial-tr	EXa	resulting in death) Last Due to (or as a consequence of):		
O. Box 68760, the death certificate be executed y the attending physician and inched for use as the burial-transit	dical	d		
68 ifficate g phy as the	뮻	V		
Box 6 eath certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		COA Para de la Coa
Box eath cert attendin for use	lan	in the past 12 months?	Ectopic pregnancy	23d. Date of delivery  Month Day Year
O. the de dy the ached	/slc	1 🗌 Yes 2 🕱 No 4 Pregnant at time of death 5 [ 9 🗍 Unknown	Other (specify)	
P.O.	Ph			
ords, Prequires that seen signed be detailed be detailed.	by	Part II. Other significant conditions contributing to death but not resulting in the u	Inderlying cause given in Part I.	e. Did tobacco use contribute to the cause of death?
cord w requir been si	ed			1 X Yes 2 No 3 Probably 4 Unknown
Records, he law requires le has been signe sge 2 should be	Completed		248	a. Was an 24b. Were autopsy findings available
The I	E			autopsy prior to completion of cause of death?
Vital   sicien: The certificate irector, pag	O	25. Was case referred to medical		Yes 2⊠No 1 Yes 2√2No
	0	examiner?	26. Place of Death Check	
Of Phys rathis		1 ☐ Yes 2 ☑ No 110 Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of	TIL SEL DOA 4 I Nursing Home 59	Residence 6
ing ing	Certification;	1 X Natural 5 ☐ Pending (Month, Day Year) Injury	Work?	Solide flow injury occurred
Divisio of or Attendiate death. Director: A	cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	
or Al	ŧ	4 Homicide  determined  28e. Place of Injury - At home, farm, str building, etc. (Specify)		ation (Street and Number or Rural Route Number, v or Town, State)
Divisi To the Hospitel or Attent within 24 hours after deat To the Funerel Director: completely filled in by the				
thou une une	edical	29a. Certifier  (Check only (C	h occurred at the time, date and place, and due	to the cause(s) and manner as stated.
he h in 24 he F		one) and manner stated.	vestigation, in my opinion, death occurred at the	e time, date and place, and due to the cause(s)
To the Hospitel within 24 hours a To the Funerel I completely filled	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		> Sheldon H. Colley Viller	P16362	4/27/05
11		30. Name and address of person who completed cause of death (Item 23a) (Type,		11-11-
7			Eastern Ave. Br	PEELS ON, STORIFFE
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	13111 17961 13	WITH CHANGE
Regis		MAY 0 3 2005 132000		

		•	For State of Maryland / State of Maryland / Registrar		ent of He cate of D			ene 0 0 5	14984
	Dhuoisi		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		JOHN B. SANN				MAY	2005	5:08 AM <sup>M</sup>
,	Examin	er	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER	R TO	OWSON	Location of Death		4c. County of Dea	ORE
	Funeral Director		5. Social Security Number 6. Sex 1.	Yrs. If U	nder 1 Year oths Days	Hours Min.	8. Date of Birth (Month, Day, ) 6/7/1932	(ear) 9. Bi C MAI	thplace (State or Foreign ountry) RYLAND
	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, To	own or Location					10d. Inside City Limits
	Maryl f sho	jo	MD BALTIMORE	TOWSO	NC				1 ☐ Yes 2 🛛 No
	death with the Maryland ms 23a or 28a-f show roust be notified at	Director	10e. Street and Number		f. Zip Code		100	g. Citizen of What C	ountry?
	h with	ai D	8542 PLEASANT PLAINS ROAD		21286			USA	
	ams ermi	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was D	ecedent of His	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
920	within 72 hours after ene. than "natural", or Ita	þ	1 □ Never Married		es 2X No	Specify:		Specify:	WHITE
Š	72 ho	ted	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's	Usual Occupa	tion uring most of worki	na 16	b. Kind of Business	/Industry
121	within lene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ife. DO NO	OT use retired)	3		TEEL INDU	ISTRY
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other then "natural", or Itams 23a or 28a-f show aumatic event. It wedical Exertiner must be notified at	Be	17. Father's Name (First, Middle, Last)  JOHN CARL SANN			18. Mother's Name		uiden Sumame)	
3	should Ind Men s marke	မှ		9b. Mailing Add	iress (Street a			City or Town, State,	Zip Code)
Š	alth a 27 is		ANNA L. SANN/WIFE 8	542 PLE	CASANT	PLAINS RI	O. TOWSO	N, MD 27	286
altimore,	ges 1 and 2 should t of Health and Men If itam 27 is marke or othar traumatic	l ÿ	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place cemes	of Disposition etery, crematory	(Name of or other place		Date 20	c. Location - City o	Town, State
Ĕ	Pag ment tant: i	١,	`4 ☐ Donation 5 ☐ Other (Specify) METR	O CREMA	TORY,	INC. 5/4		ATONSVILI	
Ball	permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 is any injury or othar trau		21. Signature of Funeral Service Licensee	> 22. Nam 8521	e and Address	<sup>s of Facility</sup> THE RAVEN BLV	JOHNSON D. TOWS	FUNERAL H	IOME, P.A.
Г	Physician /Medical		234 Part 1. Enter the disease, or complications that caused the death. Described in the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	oo not enter the	•			•	Approximate Interval Between Onset and Death
	Examiner		Due to (or as a consequence Sequentially list conditions.		J				
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter U darking Cause (Disease or injury	ce of):					
	tate be executed oblysician and the burial-transit	xan	that initiated events c.  Due to (or as a consequence Due to (or as a consequence conseque	ce of):					
8760	e be e	dicai E	d.						
9	tificat ig phy as the	ledic							
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	ath 3 □Ectop	oic pregnancy or (specify)			23d. Date of de Month	livery Day Year
۵.	uires that n signed b	by	Part II. Other significant conditions contributing to death but not resultin	g in the underly	ing cause give	n in Part I.			o the cause of death?
ecol	law requir las been si 2 should I	Completed					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u>=</u>	sician: The law certificate has t irector, page 2 s						performe	ed? death?	s 2 No
Vit	ician certifi rector	Be	25. Was case referred to medical examiner?  Hospital:		Othe	26. Place of Death			
ō		1: To	27. Manne Death 28a. Date of Injury 28l	b. Time of	28c. Injury	at Nursing Hor	me 5 ∐ Residen 28d. Describe how	ce 6 Other (Sperinjury occurred	ecity)
on	ding th: : Afte	tion	1 ✓ atural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury M	Work	? ′es 2 □ No			
Division of Vital Records,	or Atter ifter dea Director in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury · At home building, etc. (Specify)	, farm, street, fa	ctory, office		28f. Location (Stre City or Town,		ural Route Number,
<u>ا</u>	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basic of examination and manufer stated.	dge, death occu and/or investig:	rred at the time ation, in my op	e, date and place, a inion, death occurr	and due to the cau ed at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To tha within 1 To tha comple	Med	29b. Signature and title of genifier		29c. License	number	290	I. Date signed (Mon	th, Day, Year)
•			· WAL WAD		י ע	7 3 ( )		1/1105	O 2
7-	41 T		30. Name and address of person who completed cause of death (Item 23 CLAUDUIS KLIMT, MD	a) (Type, Print) 6701 N	. CHARI	LES ST.	TOWSON,	MD 21204	
ø.	Sta Registi		31. Date filed (Month, Day, Year) 32. egistrar's Signature MAY 0 3 2005	Assu	K)				
	negisti	αI	HIMI O COOL	1					

State of Maryland / Department of Health and Mental Hygiefje ( 1 - State Registrainend item to 5PFR FH C843 5/18/03/fighte of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Maynth 1, 2005 Year Verta Mae Sorrentino 2:00 p **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1719 Landmark Drive, Apt. H Harford Forest Hill If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Nu 4693 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1 □ M 2 □ F Yrs. Director 88 20, 1917 212-12-<del>4696</del> Jan. Virginia Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 🎗 ☐ No Md. Harford Forest Hill Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1719 Landmark Drive, Apt. H 21050 U.S.A. Items 23a Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) is 1 and 2 should be filed within 72 hours after of thealth and Mental Hygiene. Item item 27 is marked other then "netural", or lier other traumatic event, the Mentical Enstruments. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2√2 No Specify Specify: white 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 years homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore. Maryland 17. Father's Name (First, Middle, Last) Be Robert Howard Smith Lilia Phillips ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas Sorrentino/son 1110 Red Pump Road, Bel Air, Md. 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 0 = 6 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permil. Page Department o Important: If any injury or \* 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gdns 5/4/05 Timonium, Md. 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funetal Service J 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ONGESTIVE **Physician** HEART FAILMRE WEEKS resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY Satuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit requires that the death certificate be execu Due to (or as a consequence of): Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? FIBRILLATION 24a. Was an page 2 s autopsy performed? 1 Yes 2 No Vital Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA Certification: To this ō funeral c 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Division 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after death uneral Director: the Funeral Direc. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 To the F 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D25027 2005 winter 30 Name and address of person who ampleted cause of death (Item 23a) (Type, Print) BEL AIR MD 21014 2 JAY NORTH AVE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 3 Registrar

			For State Registrar	State of Marylan		artment of F			iene 05	14986
	Physici /Medic		Decedent's Name (First, Middle, Last,	Edwar	v d	Scot	H	2. Date of Death	Day Ye	ar ( 2 - 5 0 M
	Examin		4a. Facility Name (If not institution, give  5 +	h Nursine		4b. City, Town, o	Salti If Under 24 Hrs	more	4c. County of E	Peath Birthplace (State or Foreign
	Funeral Director			tM 2□F 81	Yrs.	Months Days	Hours Min	(Month, Day, Aug. 11,	Year)	Country) Maryland
	Marylan -f show	tor	Maryland N/A		y,TownorLo Ltimore					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 288	Oirec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	s 23a	rail	3310 Benson Ave.,		- T	2122			USA	
036	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural, or items 23a or 28a-f show any injury or othar traumatic avant, the Medical Examination at any once.	by Funerai Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: ₩₩ ]		Was Decedent of H fYes, specify Cuba I ☐ Yes 2 ⊊ No		Specify Yes or No- no Rican, etc.)		merican Indian, /hite, etc. White
21215-0036	within 72 ho ne. han "natur e Medical	Completed	15. Decedent's Edu (Specify only highest grad	cation e co <i>mpleted)</i> College (1-4or 5+)	(Give life. I	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	prking	6b. Kind of Busine	
q 7	filed v Hygie other t		12 17. Father's Name (First, Middle, Last)		Truck	Driver	18. Mother's Na	me (First, Middle, M		1 Company
/lan	Wental Wental arkad atic av	To Be	Ernest	Scott			Elizab	eth	Durh	am
Maryland	12 sho h and 7 is ma trauma		19a. Informant's Name/Relationship (Ty Eva B. Scott (Wif					ural Route Number,		
	f Healt itam 2 othar		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place		Date 2	Oc. Location - City	
<u>im</u>	Page nent o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	emoval nom State		rk Cemet	1	/05 B	altimore	, Maryland
Baltimore,	permit. Departi Import. any inj		21. Signature of Funeral Service Lice			3620 Wil	kens Ave	oudon Par ., Baltim	k Funera ore, MD	1 Home
	Pnysician		23a. Part Enter the disease, or completion, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	e cause on each line.		er the mode of dyir	ng, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or a consequence	uence of):	910				20 day
	D iii	iner	Sequentially list conditions, if any Lading Limmadal cause. Enter Underlying	Due to or as a consequence	uerice of):	, J,				
V o	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	M & 17	tia				Y-ears
8760,	icate be physicia s the bu	dicai								
P.O. Box 6	The law requires that the death certific tte has been signed by the attending p cage 2 should be detached for use as I	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq \text{Yes} \( 2 \subseteq \text{No} \) 9 \( \subseteq \text{Unknown} \)	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	1		23d. Date of Month	delivery Day Year
	gne bed	by	Part II. Other significant conditions con Diabeter 1 M	tributing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.			e to the cause of death?  Probably 4 Donknown
Division of Vital Records,	The law re tte has bee bage 2 sho	Completed	Hypertensi Atrial file	rillation				24a. Was an autopsy perform	24b. Were prior death	autopsy findings available to completion of cause of ??
/ital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					ath (Check only one		
of	Physi or this c oral dire	To 1	1 Tyes 2 No	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time of	28c. Injur Wor	4 V Nursing I	fome 5 Resider		pecify)
ion	itending death. stor: Afte / the fune	ation	1 Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury		k? Yes 2 □ No		,.,	
Divis	tal or Attending I rs after death. al Diractor: After ed in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Diractor: After this certificate h. completely filled in by the funeral director, page	Medical	(Check only 2 Medical Examinate)	ician: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	restigation, in my o	pinion, death occi	urred at the time, dat	e and place, and o	lue to the cause(s)
<b>)</b>	To the within To the Comple	M	29b. Signature and title of certifier	9/	nD	29c. Licens	9 15 3	191 4	d. Date signed (Mo j) v i  2	9, 2005
	5		30. Name and address of person who co	Ben	son A	Print) Venu	. Bal	timore	Mary	land 21227
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 3 200	Registrar's Signa	ture	li	<u> </u>	<del></del>	1	

	•	1 - For Registrer	State of Man		partment of I		1ental Hy	giene Reg. No.	05	14987
Physicia		1. Decedent's Name (First, Middle, La	st)				2. Date of De		Year	3. Time of Death
Physicia /Medica		Keith	К.		Stevenson		4	29 20	005	8:50p M
Examine	er	4a. Facility Name (If not institution, given Joseph Richy				or Location of Death timore		4c. Cou	nty of Death NA	
Funeral Director			Sex 1X M 2□F 7. Age (// 48	In yrs. last birthd Yrs	Months Days		8. Date of Bi (Month, Di 1-16	th ay, Year) -57	9. Birthp Cour	lace (State or Foreign trry)  Mã.
and		Usual Residence of Decedent  10a. State 10b. County	10	0c. City, Town o	Location				1	0d. Inside City Limits
Maryli -f sho	ţō		IA		ltimore					Yes 2 □ No
th the or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	
ath wil		1306 N. Mount St	reet		21217			Ţ	JSA	
er der	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	<ol> <li>Was Decedent of I If Yes, specify Cub</li> </ol>	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	)- 14. R	lace - Americ Ilack, White,	
036 urs aft al', or	۾	1 ☐ Never Married 2 ☐ Married 3 📉 Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 21 No	Specify:		Spe	cify: Bla	ack
21215-0036 ad within 72 hours att gliene. er than "natural", or the Medical Exem.	Completed	15. Decedent's E (Specify only highest gr		16a. De	cedent's Usual Occur ive kind of work done e. DO NOT use retire	pation during most of work	ina	16b. Kind of	Business/Inc	dustry
within within then	du	Elementary/Secondary (0-12)	College (1-4or 5+)			nd)				
d 2 illed Hygin other	Be Co	10th grade  17. Father's Name (First, Middle, Last	)	Cus	stodial	18. Mother's Name	e (First, Middle	Var:		
/lan	10 B	Robert		Stevenso	on	Paul:	ine		Tay.	lor
Maryland d 2 should be file th and Mental Hy 27 is marked oth traumatic event	i	19a. Informant's Name/Relationship (	** '		ailing Address (Street					Code)
C = 14 F		Donna Savage  20a. Method of Disposition	Sister		06 N. Moun		ltimore	, MQ.	21217	wn State
Pages nent of I ury or o		N☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci	Tremoval nom State		sposition (Name of crematory or other place armel Cem.	5-5-			alk, Mo	
Baltimore, permit. Pages 1 a Department of Her Important: If item any injury or othe once.		21. Signature of Funeral Service Lice	nsee		22. Name and Addre	ess of Facility		Baltimo		
N. m gorag			/ few		_ March F.		The state of the s	E. Nor	th Ave	
		23a. Part1. Enter the disease, ir com shock, or heart failure. List only Immediate Cause (Final	Λ		1 (					Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to (or as a	-	munodefic	iency syr	done			2 years
Examiner		Sequentially list conditions,	b =====							
O 7 8 5	iner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):						
639 05 60, A seccuted and arrial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):						
4 (39) (68760, c licate be executed physician and is the burial-transit	dlcal		_ d							
0, 0	Med	IF FEMALE:								
Box 6 Box 6 Beath certification attending processes as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death	3 Ectopic pregnanc	y			Date of delive Month	ry Day Year
ecords, P.O. Box 6 law requires that the death certif as been signed by the attending 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	ie or death	5 Other (specify)					
S, P es that igned the be detailed.	by P	Part II. Other significant conditions of	1 1	ot resulting in the	e underlying cause giv	ven in Part I.	23e. Did t	obacco use co	ontribute to th	e cause of death?
cords		Hepa	titis C	-			10	Yes 2 No	3 Prob	ably 4 Unknown
y was by se 2 s 2 s 2 s 5 s 5 s	ompleted						24a. Was	an 24b osy ormed?	b. Were autoper prior to condeath?	bsy findings available inpletion of cause of
-) - <del>-</del> d G	ပို့ .	25. Was case referred to medical				26. Place of Death	1 Tes	2 No		21 <b>X</b> No
	0	examiner? 1 ☐ Yes 2 No	Hospital: 1   Inpatient	2 ER/Outpar	tient 3 DOA Oth				ther (Specify	Hospice
In the standard of the standar	atlon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time Injur	y Wor	ry at rk?	28d. Describe			
isio	icat	2 Accident investigatio 3 Suicide 6 Could not b	e One Diese of Initial	- At home farm	-	Yes 2 □ No	28f Location /	Street and Nun	nher or Dura	Route Number,
Divisi Divisi al or Atter s after dea al Director d in by the	Certific	4 Homicide determined	building, etc. (S	Specify)	street, ractory, onice		City or To	vn, State)	nber or nurar	noute Number,
j <b>a</b> jo <b>ja</b>	edical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medicel Example 1	nysician: To the best of m niner: On the basis of exa and manner stated	amination and/or	eath occurred at the tir investigation, in my o	me, date and place, a opinion, death occurre	and due to the ed at the time,	cause(s) and r date and place	manner as sta e, and due to	ated. the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	QM		29c. Licens	,	_	29d. Date sign	ned (Month, L	Day, Year)
		1 Juni	PRULLI MO			1788 (M	9)	4/3	0/200	5
3		30. Name and address of person who	completed cause of death	h (Item 23a) (Type	be, Print) Iron Stree	t Bel Air	MO.	21014		
State Registra	_	31. Date filed (Month, Day, Year)  MAY 0 3	32. Registrar's	Signature	han Stree Sports	/ /				

			1 - For State Registrar	State of Marylar		rtment of Hea	eath		Reg. No.	005	14988
	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, La Annet  4a. Facility Name (If not institution, give Tohns Hockin Roy	e street and number) + 1		4b. City, Town, or Lo		2. Date of Dea Month	29g	Year 2005 County of Death	3. Time of Death 12:45 M
	Funeral Director		5. Social Security Number 6. 5	1		If Under 1 Year If	Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day October	h , <sub>Year)</sub> 10 <b>,</b> 195	9. Birth Cou	place (State or Foreign Intry)
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinations the notified at	Funeral Director	MD. Baltimo  10e. Street and Number 625 South 48th St  11. Marital Status	re D	ry, Town or Loc undalk	ation  10f. Zip Code  2122  (as Decedent of Hispa Yes, specify Cuban, k			US	en of What Cou A 4. Race - Amer Black, White	ican Indian,
0000-01717	d within 72 hours after giene. It than "natural", or II	Completed by Fu	1 Never Married 2 Married 3 Widowed 4 X Divorced  15. Decedent's E (Specify only highest gra  Elementary/Secondary (0-12)  12 years	1 Tes To No If Yes, Give Year or Dates:	16a. Decede (Give k life. D	_	Specify: n ng most of workin		16b. Kind		ite
ממואומיים י	ould be Mental parked o	To Be C	17. Father's Name (First, Middle, Last James Sumpter 19a. Informant's Name/Relationship (		19b. Mailing	18.  Address (Street and	Mother's Name Kate Sur Number or Rural	mpter Route Numbe	Maiden S	lumame) Town, State, Zi	,
LINDIC, IV	Page nent c ant: # ury or		Sandra Joyce  20a. Method of Disposition  1   XBurial 2   Cremation 3    4   Donation 5   Other (Special Service Lice)	(y) Oa	Place of Disposi cemetery, cremi k Lawn	tion (Name of atory or other place) Cemetery	May 3	, 2005	20c. Loca Dun	ation - City or T dalk, M	own, State
Da			23a. P. nt. Enter the disease of comshock, or heart failure. Jis only	plications that caused the deat	h. Do'n t enter	Name and Address of pnnelly Fur 10 Sollers the mode of dying, so	S POINT	Road, L	Junua	lk,P.A. lk,Md.	21222 Approximate Interval Between Onset and Death
	Physician /Medical Examiner	her	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	1	IVIC					24 hours 2 days
, , , ,	sate be executed thy sician and the burial-transit	lical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):						2 days
.O. DOA O	ig p as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 🏋 Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	l death 3 □E	Ectopic pregnancy Other (specify)			23	d. Date of deliv	ery Day Year
ב יב	w requires that the death cer been signed by the attendin should be detached for use	by	Part II. Other significant conditions of	contributing to death but not res	ulting in the und	derlying cause given in	Part I.		es 2		he cause of death?
ומו חבר	sician: The law s certificate has b lirector, page 2 s	Be Completed	25. Was case referred to medical examiner?			26	. Place of Death		med? 2D No	24b. Were auto prior to co death? 1 \( \sum \text{Yes}	opsy findings available impletion of cause of
	ng Phy fter this ineral c	ertification: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury at Work?	4 ☐ Nursing Hom 28 2 ☐ No	e 5 Reside 3d. Describe he			(y)
	To the Hospital or Attendi within 24 hours after death.  To the Funeral Diractor: A completely filled in by the fu	O	3 Suicide 4 Homicide  6 Could not be determined	building, etc. (Specification)	y) 	occurred at the time, d	late and place, ar	City or Town	n, State) ause(s) ar	nd manner as s	al Route Number,
	To the Hc within 24 I To the Fu completely	Medical	(Check only one)  2 Medical Example 29b. Signature and title of certifier	niner: On the basis of examina and manner stated.	tion and/or inve	29c. License nu	n, death occurred mber	d at the time, d	ate and p	signed (Month,	o the cause(s)
-	5 Sta	te.	30. Name and address of person who	completed cause of death (Item	SHETT	rint)	3a Hin	nore,	WD	212	24
	Registr			3 2005	K	South 1					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U - State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Yeer PM SUEZZESK 2005 Ma ntoinette 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Bruth 1 Year | It Under 24 Hrs. | Hours | Min. (, EUTEL 5. Social Security Number Medica 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Months Days 1 □ M 2 😾 F Feb8,1924 214-18-0459 81 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 AYes 2 No Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21224 426 S. Elrino Street Was Decedent of Hispanic Origin? (Specify Yes or Nott Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritat Status Black, White, etc. 1 Yes 3 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. SpecifyWhite 3℃ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Julia Stocker Michael DellaPenna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21221 1562 Williams Ave. Baltimore MD George Svezzese /son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State Baltimore MD 5/5/05 LorrainePark \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 onne Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Pent1. Enter the disease, or pur ications that caused the deal shock, or heart failure. List only one cause on each line. tmmediate Cause (Final astrointestina disease or condition resulting in death) Due to (or as a consequence of): Bacter obadole. Saluentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 91dación that initiated events Due to (or as a consequence of): resulting in death) Last Cardiomyopathi Schemi 279119 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

permit. Peges 1 Department of H Importent: If Ite eny injury or ot once.

Examiner

Physician

/Medical

**Examiner** 

10a. State

by Funeral Director

Completed

Be

**Funeral** 

Director

i Health and Menial Hygiene. Item 27 is marked other then "natural", or items 23a or 28e-f show other traumatic event, I'm Medical Examinat must be truitlied at

filed within 72 hours after

Peges 1 and 2 should

Baltimore, Maryland 21215-0036

o

Records, P.

Division of Vital

or Attending

attending physician for use as the buria Be Completed by Physician/Medical signed by the at d be detached fo been page 2 s has certificate Certification: To After this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 Unknown

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

	examiner?		 	 1
	1 🗆 Yes	2 No		
7.	Manner ot	Death		

25. Was case referred to medical

1 Natural

2 Accident

3 🗀 Suicide

29a. Certifier

4 Homicide

Hospital:

1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only		on and/or investigation, in my opinion, death occurred at the tim	
one)	and manner stated.		
20h Signature and	title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

29c. License number

🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

5 Pending investigation

6 ☐ Could not be

determined

RES-000 pleted cause of death (Item 23a) (Type, Print)

State Registrar

Medical

31. Date tiled (Month, Day, Vear)

MAY 0 3 200

Eastern Ave, Baltimore, MD 21224

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day J OHN ANTHONY SEBREE APRIL 2. 8. 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deeth UPPER CHEZAPEAKE MEDICAL CENTOR BOLANK HARFOND If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State Country) |
April 18, 1948 | Maryland Sex XXM 2□F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 213**-**54-1186 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits treumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itama 23a 325 Catherine Street 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 (XYes 2 □ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Btack, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ 3 ☐ Widowed 4 ☐ Divorced "naturel', White Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrician Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be pe and Mental Carev **Ambrose** Sebree Rosie Theresa 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health al Importent: If item 27 Is any injury or other treu <u>once</u>. Rosie T. Sebree - Mother 325 Catherine Street, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 S 4 Donation 5 Other (Specify 3 Removal from State Gardens of Faith 5-02-05 Baltimore, Maryland 21. Signa u 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, Maryland 21014 ard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition Physician HASLUD resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Rheumstord ANTHATIS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 (XNo 24a. Was an autopsy performed? 1 ☐ Yes 2/**Z** No Physicien: funaral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ €R/Outpatient 3 ☐ DOA this 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospitel or Attending 1 Natural 5 Pending 24 hours after death.

Funeral Director: A investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Medical 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 021809 mush DME APMIL28, 2005 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 15PRABHU 2336 YORK ND TIMONIUM 31. Date filed (Month, Day, Year) 32 Registrar's Signature MAY 0 3 2005 Registrar

			For State	State of	of Marylar		artmer					gien <b>e</b> () ()	5	14991
			Registrar  1. Decedent's Name (First, Middle, L	ast)		061	uncat	e or L	Jeani		2. Date of Dea	Reg. No.		3. Time of Death
	Physicia			uerite	Schri	urn					Month	01 200	Year )5	7:05 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, g			um	4b. City,	Town, or	Location of	of Death	11aj	4c. County		
	=Xaiiiii	•	Chesapeake Hospi	ce House	Э			Linth	nicum			Anne	Arı	undel
	Funeral			Sex 1 □ M 2 🗓 F	7. Age (In yrs.	• * *	If Under	1 Year Days	If Under Hours	4.41-	8. Date of Birth	1924	9. Birthp	place (State or Foreign
	Director		579-30-1466	1   М 2   ДД Г	8	O Yrs.					May 17	1924		DC DC
	land ow		Usual Residence of Decedent  10a. State  10b. County		10c. Ci	ty, Town or Lo	cation		_					10d. Inside City Limits
	Mary -f sh	to	Maryland Anne A	Arundel				Pas	adena	ì				1 ☐ Yes 2 🔀 No
	h the or 28s a routi	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of V	√hat Cou	ntry?
	23a c	aiD	8050 Mayer Aven	ue				21	1122				USA	
	tems	nue	11. Marital Status	Armed Fo		J.S. 13.	Was Dece	dent of His	spanic Ori n, Mexicar	igin? (Spec n, Puerto F	orfy Yes or No- Rican, etc.)		e - Americ k, White,	can Indian, etc.
36	rs afte	y Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Gi Year or D	ive		1 🗆 Yes	2 🛛 No	Specify:			Specify	: Wt	nite
8	2 hou atura	led	15. Decedent's	ducation		16a. Dece	dent's Usu	al Occupa	ition			16b. Kind of Bu	siness/ir	dustry
212	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show he Medical Exercine must be notified at	Completed by Funeral	(Specify only highest g	ra <i>de completed)</i> College (		(Give	DO NOT u	se retired,	)	t of workin	ig .			
2	ed wil	Con	10				Bar	Tend					averr	1
Maryland 21215-0036	be fill	Be	17. Father's Name (First, Middle, Las		ayne				18. Mothe			<i>Maiden Sumam</i> phard	a)	
ž	should ind Men ind Men ind marke	၀	William R.  19a. Informant's Name/Relationship		ayne	19h Mailir	na Address	(Street a				r, City or Town,	State 7ii	Code
	nd 2 s ulth an 27 ls r trau		Brandy Deserio		ughter)							MĎ 2112		. 5000)
ē,	of Heat item othe		20a. Method of Disposition			Place of Dispo	sition (Nam	me of other place	9)	√ay D	at 02	20c. Location -	City or To	own, State
Ē	Pages ment of I ent: If its ury or o		1 ☐ Burial 2 ∰Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec		State	tro Cre	-			20				Maryland
Baltimore,	permit. Pages I and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at one.		21. Signature of Funeral Service Life	anyee A D			2. Name ar 3111					s Funer lena, MD		ome, P.A. 22
			23a. Part1 Enter the disease, or conshock, or heart failure. St onl	nplication that	aused the deat	th. Do not ent	er the mod	de of dying	g, such as	cardiac or	respiratory arr	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CY	**	01	ch	+2-		R	\	1).	6 = 1 6	Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):					199 6 196	1		
	LAGITITICI	_	Sequentially list conditions,	b. — Due to	(or as a conseq	ulence of):					-			
	uted Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	20010	(0) 23 2 00 1300	(Borico or).								
Ć	exectin and rial-tra	Еха	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):								
8760	ficate be executed physician and sthe burial-transit	dical	•	d										
9	ertifica ling ph e as tl		IF FEMALE:											
Вох	The law requires that the death certifule has been signed by the attending to has should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	1□Live I	itcome of pregna birth 2 Feta	aldeath 3[	Ectopic p					23d. Date Mor		ery Day Year
0	the de	ysic	1 Yes 2 No	4⊟ Pregi 9⊟ Unkn	nant at time of o	death 5L	Other (sp	овсту)						·
٥.	signed by	y Ph	Part II. Other significant conditions	contributing to d	- leath but not res	sulting in the u	nderlying o	ause give	n in Part I		23e. Did to	bacco use contr	ibute to t	he cause of death?
Records,	quires n sigr utd be										1	es 2 🗆 No	3 🗌 Prot	oably 4 Unknown
ပ္ပ	aw requir is been si 2 should	piet									24a. Was a		Vere auto	ppsy findings available
		Completed									autops perfor	med? d	eath?	mpletion of cause of 2 \( \subseteq \text{No} \)
/ita	ysicien: The is certificate hidirector, page	Be	25. Was case referred to medical examiner?							of Death	(Check only or	10)		
<del>_</del>	Physicien: this certificatel director.	o L	1 Yes 2 No		Inpatient 2				4 🗆 Nu		ne 5 Reside			y Hospice
- LO	ding I h. After funer	tion	27. Mapner of Death  Natural 5 Pending  Accident investigati	1	oth, Day Year)	28b. Time of Injury	M	28c. Injury Work	at ? ∕es 2 🔲		ad. Describe no	ow injury occurre	30	
Division of Vital	Attender deat	fica	3 ☐ Suicide 6 ☐ Could not	28e. Place	e of Injury - At h								or Or Rura	al Route Number,
á	ospitel or A hours after uneref Direc ly filled in by	Certification;	4  Homicide determine	build	ing, etc. (Specil	fy)					City or Tow	n, State)		
	H 224	Medical (	29a. Certifier Check only one) Certifying F	hysician: To the miner: On the b and man	e best of my kno basis of examina oner stated.	owledge, deatl ation and/or in	occurred vestigation	at the tim	e, date an inion, dea	d place, a	nd due to the c d at the time, d	ause(s) and mar late and place, a	ner as s	tated. the cause(s)
	To the within 2 To the complei	Me	29b. Signature and title of certifier	1,			290	c. License	number			9d. Date signed	(Month,	Day, Year)
	~7		16 2	1	MD			DS	55	18	7	5/2	10	j
2			30. Name and address of person who	completed cau	se of death (Iter	n 23a) (Type,	Print)	1	1		1		1	MA
	Sta	te	31. Date filed (Month, Day, Year)	32. F	gistrar's Signa	atur	Cl o	77	D	Jen	~e 19	mapa	1.5	
	Registr		MAY 0 3	2005	Vaves	No P								

Edward Allen Thompson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-02705 State of Maryland / Department of Health and Mental Hygiene R.J 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Edward Allen Thompson 2005 03:25 p /Medical April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Dagman Hall -- Room 123 Hagerstown 5. Social Security Number unk 6. Sex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Apr 23, 1 **Funeral** 9. Birthplace (State or Foreign Country) 1 X M 2 □ F Director 46 Yrs. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28e-f show other treumetic event. The Medical Event at most ke notified at 10d. Inside City Limits MD Washington Director Hagerstown 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Dagman Hall Room 123 21740 death Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. unk 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry unk unk (Specify only highest grade completed) d 2 should be filed within 7, in and Mental Hygiene.
7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) Be unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permil. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is m any injury or other treum once. O.C.M.E. 111 Penn Street Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State `4 □Donation 5 Nother (Specify) in state 21. Signature of Funeral S Ronal State Anatomy Board 655 W. Baltimore Street noen// Baltimore, MD 21201 23a. Part it Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Gastrointestina hemowhage /Medical Due to (or as a consequence of): Examiner Ruptived varices Sequentially list conditions Director (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury burial-transit certificate be executed alcoholish Chronic that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy The law requires that the death Por in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Dav Year 5 Other (specify) P.O. 1 the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Artherosclerotic cardiovascular disease 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1. □ Yes 2 □ No 24a. Was an page 2 certificate has autopsy performed? 2□No 1 Xes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:  $_4$  Nursing Home  $_5$  Residence  $_6$  Other (Specify) At scene 1XYes 2☐ No P After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Hospitel or Attending 1 Natural 2 Accident 5 Pending death, 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a ical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

(Check only one)

29b. Signature and title of certifier

Treamose

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lureen

within 2 To the

NUD

M.D

Registrar's Signature

2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number OCME

111 Penn Street

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21201

April 18, 2005

			For State Registrar	State of Mar		artment of H rtificate of L		-	giene ()	)5	14993
	Physic	ian	1. Decedent's Name (First, Middle	, Last)				2. Date of De		Year	3. Time of Death
,	/Medi	cal.	JOHN WILLIAM T			1		Hozil		2005	12:10 PM
	Exami	ner	4a. Facility Name (If not institution,  NORTH ARUN)		τ Λ Ι	4b. City, Town, or GLEN F.	Location of Deal		4c. County	_	INDEL
	Funeral		5. Social Security Number	6. Sex 7. Age (	In yrs. last birthday	If Under 1 Year	If Under 24 Hrs	8. Date of Bir	th		ce (State or Foreign
	Director		215.48.1390	XX 2 F	56 Yrs.	Months Days	Hours Min.		l, 1948	Country	MD
	land ow		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or L	ocation				10d	I. Inside City Limits
	ath with the Maryland 23a or 28e-f show	to	MD ANNE	ARUNDEL	PASADEN	٨					1 ☐ Yes 2 ☐ No
	with the a or 28e	Director	10e. Street and Number	INONDIA	TADADEN	10f. Zip Code			10g. Citizen of V	What Country	/? XX
	death w	rai	8048-B ABBEY			2112			US		
	Items Irer	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Even		Was Decedent of Hi If Yes, specify Cubai	spanic Origin? (S n, Mexican, Puer	pecify Yes or No to Rican, etc.)	- 14. Raci Blad	e - American ck, White, etc	Indian, c.
036	hours after turel', or Ite	by	3 ☐ Widowed ★★ Divorced	ed XXYes 2 □ No If Yes, Give Year or Dates: <b>V</b>	TETNAM	1 ☐ Yes 2 ☐ No	Specify:		Specify		7
21215-0036	should be filed within 72 hours after dea nd Mental Hyglene. marked other then "neturel", or Items metic event, tre Madical Exeminer	Completed	15. Decedent' (Specify only highes	's Education	16a. Dece	dent's Usual Occupa	ation	rking	16b. Kind of Bu	WHITE subnivesenian	
121	l within iene.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,	)	nuig			
	filed v Hygie other 1	ပ္ပ	12 17. Father's Name (First, Middle, L	_ast)	ELEC	TRONIC EN		me (First, Middle,	GE ME		
lan	ould be Mental arked o	To Be	WILLIAM H. TITU	JS				ANNE MYI		16)	
Maryland		-	19a. Informant's Name/Relationsh	nip (Type, Print)	19b. Maili	ng Address (Street a				State, Zip Co	ode)
Σ,	and 2 ealth m 27 in		LAILANI RYAN	DAUGHTER		STEWART A	VE GLEN	BURNIE,	MD 2106	1	
Baltimore,	Pages 1 nent of H ant: If ite ury or ott		20a. Method of Disposition  1 WYurial 2 Cremation		20b. Place of Dispo cemetery, cre-	sition (Name of matory or other place	9)	Date	20c. Location -	City or Town	n, State
Ħ	artmen ortent: injury		*4 □Donation 5 □Other (Sp			DGE CEMETI		and the second s	ELKRID	GE, MD	
Ba	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tree		K. GREGORY F	1		INK°FUNERZ 26 CRAIN I			IE. MD :	21061	
£,			23a. Part1. Enter the disease, or on shock, or heart failure. List of	complications that caused the only one cause on each line.	e death. Do not en	er the mode of dying	, such as cardiad	or respiratory ar	rest,	A <sub>l</sub>	pproximate terval Between
) -	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a. No	NHOJG	Kins L	YMPH	omit		0	nset and Death
	Examiner.		,	Due to (or as a c		1200					
	- 45	je l	Sequentially list conditions, if any, leaving to immediate	b. Due to (or as a c	orisequarice of).	<i>6794</i>	(ho~			_	
	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. GE	NI-EST.	SUE UE.	ART F	FICCIR	E		
90,	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or as a c							
		dical		d		_					
Вох 6	death certific attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy				02d Date		
. B		iclar	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		Ectopic pregnancy Other (specify)			Mon	e of delivery oth Da	y Year
P.0	that the de ned by the a detached f	hys	9 🗆 Unknown	9□ Unknown							
S,	gr be	by	Part II. Other significant condition	s contributing to death but n	ot resulting in the u	nderlying cause giver	n in Part I.		bacco use contri		
oro	w requir been si should	eted						1 🗆 Y	es 2□No	3 Probably	y 4 ⊠Unknown
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		e Co	25. Was case referred ≱o medical	1				1 ☐ Yes	2 No 1	Yes 2	□ No
Ş	d is	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ER/Outpatien	Othor	_	th <i>(Check only or</i> ome 5 ☐ Resid		r (Spacify)	-
			27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injury Work	at		ow injury occurre		
sio	Attending ir death. ector: After by the fune	catl	2 Accident investiga 3 Suicide 6 Could no	ation		M 1 □ Y	es 2 No				
-	i fte	Certification:	4 Homicide determin		<ul> <li>At home, farm, str. Specify)</li> </ul>	eet, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	r or Rural Ro	oute Number,
_	To the Hospital within 24 hours a To the Funerel Completely filled it		29a. Certifier 1 Certifying	Physician: To the best of m	v knowledge, death	occurred at the time	date and place	and due to the c	ausa(s) and man	oner en state.	d
	n 24 h	edical	(Check only 2 Medicel E	xaminer: On the basis of ex- and manner stated	amination and/or inv	estigation, in my opi	nion, death occur	red at the time, d	late and place, ar	nd due to the	cause(s)
	To the within To the comp	Σ	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed	(Month, Day	(Year)
	~			) libe		300	55703		17 prie	23.	2005-
15			30. Name and address of person w			Print)					2005 MS 2106
1	Sta	te.	31. Date filed (Month, Day, Year)	Brish C C	Signature /	2 UNDEZ	405,7	THE GO	i- Bi	11211-	MS 2106
	Registr	26	MAT U 3	2005 Garene	Signature	ME					

			1 - For State Registrar	ite of Maryland / I		tment of I				ne () (	15	14994
	Dhysia		Decedent's Name (First, Middle, Last)		-			2. Dat	e of Death			3. Time of Death
	Physic /Medi		Ellen Faye	Turner				Apr		8 200	) 5	9:27ам
7	Examir	ner	4a. Facility Name (If not institution, give street	·	4	b. City, Town, o				4c. County		
			4159 Webster Lapi  5. Social Security Number 6. Sex	7. Age (In yrs. last bi	eth double 1	Hav:		Grace		паг	ford	
н	Funeral Director		217-38-4490 1 M 2			Months Days		Min. May	of Birth nth, Day, Y	ear) 1940	9. Birthp	place (State or Foreign TVirginia
			Usuel Residence of Decedent					μ.ω.		1340		
	arylar show	_	10a. State 10b. County  Md Harford	10c. City, Tow							1	0d. Inside City Limits
	he M	ecto		Hav		De Gra	ce 					1 ☐ Yes 2X No
	ath with the Marylan 23e or 28e-f show ust be notified at	Ö	10e. Street and Number 4159 Webster Lapi	dum Poad		10f. Zip Code 210	70			. Citizen of	What Cour	ntry?
	72 hours after death with the Maryland netural', or items 23e or 28e-f show ard Examiner out be notified at	Funeral Director		us Decedent Ever in U.S.	13. Wa:			gin? (Specify Ye		SA 14 Bac	e - Americ	ean Indian
9	urs after dea al', or items Exmitier or	五	1 Never Married 2 Married 1 [	ned Forces? ]Yes 2. MNo	1			gin? (Specify Ye: n, Puerto Rican, e	etc.)	Bla	ck, White,	etc.
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12	within ene. then "	du		llege (1-4or 5+)						own ł	ome	
d 2	filled Hygi ther	e Cc	10th 17. Father's Name (First, Middle, Last)		но	memake		r's Name (First,	Middle Ma	iden Suman	ne)	
lan	D 2 2 0	To B	Orville Jack W	ygal				orgia C			,	
Maryland	s 1 and 2 shou f Health and M item 27 is mar other treumeti	-	19a. Informant's Name/Relationship (Type, Pri	nt) 19b	. Mailing A	Address (Street		r or Rural Route				Code)
	and 2 ealth a m 27 i		Diana Bailey /dau		4159	9 Webs	ter I	apidum	Roa	d Hav	reDe	Grace MD
ore	0 - = =		20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐ Remova	20b. Place of cemeter	f Disposition	on (Name of ory or other place 1Ceme		Date	200	c. Location -	City or To	wn, State
Ē.	Pa nen int:		'4 □Donation 5 □Other (Specify)	HOTT				5/2/05	В	altin	nore	MD
Baltimore,	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licensee	onnelle	22. N	ame and Addre		Conne				neofEssex
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	Priysician	i g	Immediate Cause (Final disease or condition		ne						1	nset and Death
	/Medical Examiner		resulting in death)	oue to or as nsequence	아: 1	1	127	1	1			gine
	ZAGIIIIICI	er	Sequentially list conditions, if any, leading to immediate	MUMU ()	1/5/1	ueru	-DI-	Lmona	y de	Men		Lylan'
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury that initiated events	Louis a consequence	in ha	Same:	/		/		0	- 1
,	execun n and ial-tra	Examin	resulting in death) Last	ue to (dias a consequence	of):	unce						yean
8760,	cate be executed physician and the burial-transit	dicall		''								
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Вох	death certiff e attending id for use as	Physiclan/Me	200. Tras decedent pregnant	es, outcome of pregnancy Live birth 2 ☐ Fetal death	3∏Ect	topic pregnancy	,				e of deliver	y
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ds,	w requires that been signed by should be det	i by	Part II. Dther significant conditions contributing	ig to death but not resulting in	n the under	rlying cause give	en in Part I.	23e				e cause of death?
Ö	requiper / redu	etec							1 105	2 No		
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_		e Co	25. Was case referred o medical					10	Yes 2	No 1	Yes 2	2 🗆 No
Vital		o Be	examiner?  1 Yes /2 No Hospital	1 ☐ Inpatient 2 ☐ ER/Ou	trationt 5	3 DOA Othe		of Death (Check	/	a CO.		
	ra th	Projection in	27. Manny of Death 28a.	Date of Injury 28b. T	ime of	28c. Injun	4 □ Nu≀	sing Home 5		e 6 ⊟Othe		
0		atlo	1	(Month, Day Year) It	njury !	Worl M 1□	k? Yes 2 ⊟N	lo				
Division	I or Attend after death Director: ,	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, far building, etc. (Specify)	rm, street,	factory, office		28f. Loca	tion (Street or Town, St	and Number	er or Rural	Route Number,
	urs aff											
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical	(Ollock Olly 2   Medical Examiner: Or	To the best of my knowledge the basis of examination and manner stated.	i, death occ d/or investi	curred at the timi igation, in my of	ne, date and pinion, death	place, and due to occurred at the	o the cause time, date	e(s) and mai and place, a	nner as sta ind due to t	ited. the cause(s)
	withir To th comp	Me	29b. Signature and title of certifler	14.0		29c. License	number		29d.	Pate)signed	(Month, D	ay, Year)
	7		• MM/	V ( ) .		1/1	147	43	4	1/2/	(1)5	
	X		30. A my and address of person who complete	cause of death (Item 23a) 6	Type, Print	11-1	+ + /-	1 11		1200	22	
			HUJAMAN G	T50 10 10	pu	d M		DUC	1911	460	1	
	Sta Registra	1000	31. Date filed (Montal Party 91) 3 2005	32. Agistrar's Signature		40						

ORIGINAL

			1 - For State Registrer	State	of Marylar		artment of H		Mental Hy	giene Reg. No.	005	14995
			1. Decedent's Name (First, Midd	le, Last)					2. Oate of De	ath		3. Time of Death
	Physici /Medio		Charles		Otis		Tilghman	n	Month 4	27	2005	2:35p.M
	Examir		4a. Facility Name (If not institutio	n, give street and nu	ımbər)		4b. City, Town, o	r Location of Dea	ath		County of Death	<del>-</del>
п			8509 Church	Lane			Randa11	stown		Ba	alto	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hr		h Voorl	9. Birth	place (State or Foreign
н	Director		218-18-7582	1 <u>X</u> M 2□ F	7.7	7 Yrs.	Months Days	Hours Mir	1. (Month, Da 8-28			Md
	pu *		Usual Residence of Decedent  10a. State 10b. County		100 0	ty, Town or Lo						
	aryla sho	7	Toa. State		100.01	ty, Town or Lo	cation					10d. Inside City Limits
	Ba-f	Director	Md	Balto		Randa1						1 ☐ Yes 2 X No
	with t	ā	10e. Street and Number				10f. Zip Code			10g. Citîz	en of What Cou	ntry?
	s 23	ral	8509 Church 1				211				JSA	
	er de Item	Funeral	11. Marital Status	Armed F		I.S. 13. \	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	.   1	<ol> <li>Race - Ameri Black, White</li> </ol>	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	ried IXIYes, Gi IYes, Gi Year or D	2 □ No ive		I ☐ Yes 2 🛣 No	Specify:			Specify: Blad	ck.
21215-0036	d within 72 hours after death with the Maryland piene. Ir than "natural", or Items 23a or 28a-f show Ite Modical Examiner must be notified at	ed		nt's Education	Jates.	16a Decer	lent's Usual Occup	ation	1		d of Business/Ir	
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212	e filed within all Hygiene. I other than " vent, It's Max	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+) N/A		ehouse M			Dura	alite Ti	rucking
	Hygothe ent.	BeC	17. Father's Name (First, Middle,	Last)	1,7.21			18. Mother's Na	me (First, Middle,	Maiden S	Sumame)	
Maryland	TI = 0 0	To B	Frank Tilghman	ı				Annie	Brown			
ary	2 shou and M Is mar	-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailin	g Address (Street	and Number or F	Rural Route Numbe	r, City or	Town, State, Zij	Code)
	1 and 2 Health a em 27 Is		Stephanie D. J	Johnson -	Daughte							
Baltimore,	ges 1 and 2 should it of Health and Men if item 27 is marke or other traumatic		20a. Method of Disposition			Place of Dispos	sition (Name of natory or other place	(a)	Date	20c. Loc	ation - City or T	own, State
Ĕ	permit. Pages 1 Department of H Important: If ite any injury or ot		1 Surial 2 Cremation 1 Donation 5 Other (5		State	-	Forest '	1	-2005	Owin	ngs Mill	e Md
att	permit. Departm Importa any inju		21. Signature of Funeral Service	Licensee			Name and Addre				e, Md.	21215
m	8 2 E E B		Mun D	X ret	2	M	arch F.H	. West	4300 Wa			
П	5		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat	h. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory ar	rest,		Approximate
	Parysician		Immediate Cause (Final disease or condition									Interval Between Onset and Death
	/Medical		resulting in death)	Due to	(or as a conseq	juence of):	711016	1	ILERS E		-	10 hr
	Examiner		Contractable that a combined	. PC.	RIPLE	e RAC	LASO	CULAR	iseks e	en!	9	10 4
		ner	if any, leading to immediate cause. Enter Underlying	Due to	(or as a conseq	uence of):	100 - 3477				4	
	nd rans	Examiner	Cause (Disease or injury that initiated events	c <i>D/</i> .	MBELLE	25 /	nelli	TUS				10 kg
Ö,	e exe ian a urial-	ĕ	resulting in death) Last	Due to	(or as a conseq	uence of):						,
38760,	icate be executed physician and the burial-transit	dical		d								
-		a)	IF FEMALE:									
Вох	The law requires that the death certificate has been signed by the atlending places 2 should be detached for use as to	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	tcome of pregna pirth 2  Feta	I death 3 🗌	Ectopic pregnancy			23	d. Date of delive Month	ery Day Year
<u>.</u>	that the death ned by the atter detached for u	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregr 9□Unkn	nant at time of do own	eath 5□	Other (specify)				MOHIT	Day feat
P.O.	hat the	Ph	Part II. Other significant condition	ons contributing to d	eath but not rec	ulting in the us	darkina causa au	on in Class I	220 Didto	baasa us		
ds,	signed l	by	Tatti, otto signifeant contain	one contributing to d	oau but not tes	aiting in the un	denying cause give	en in Parti.		es 2 🗍		ne cause of death?
OL	w require been si should	etec								B3 2 🗆	140 3 FIOL	ADDIN TOTALIONI
Records,	has l	Completed							24a. Was a autops	Sy	prior to co	psy findings available mpletion of cause of
2	cate								1 Yes	2 0 No	death? 1 ☐ Yes	2 No
<u> </u>	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		ath Check on on	18)		
o	Phys this ral dii	- To	1 ☐ Yes 2 💢 No 27. Manner of Death			ER/Outpatient		4 🗀 Nursing i	-		Other (Specif	y)
UC.	ding I h. After funer	lon	1 Natural 5 ☐ Pendin	9	th, Day Year)	28b. Time of Injury	28c. Injury Work	(?	28d. Describe ho	ow injury (	occurred	
<u>S</u>	death.	ical	2 Accident investig 3 Suicide 6 Could	not be	of loiune. At he	ome form etro	et, factory, office	Yes 2 □No	20f t pasting (C)	brook and	Number of Dum	/ O t- N/t
Division of Vital	lor A after Direct	Certification:	4 Homicide determ	buildi	ng, etc. (Specif)	y)	et, ractory, office		28f. Location (St City or Town	n, State)	Number of Aura	I Houte Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1X Certifyin	g Physician: To the	best of my kno	wledge death	occurred at the time	e date and place	and due to the o	Zuen/e) c	nd manner en -	atad
	To the Hospita within 24 hours To the Funeral completely filled	Medical	(Check only 2 Medicel one)	exeminer. On the b	asis of examination as the stated.	tion and/or inv	estigation, in my op	pinion, death occi	urred at the time, d	ate and p	lace, and due to	the cause(s)
	ro th ro th compl	Me	29b. Signature and title of certifie				29c. License	number	2	9d, Date :	signed (Month,	Day, Year)
	- 3 - 0		>//h	Jam	TO MA	51	D 1	5480	7	4/:	29/2	005
	141	+	30. Name and address of person	who completed caus	e of death (Item	1 23a) (Type P	Print)	, ,		-		
	le		MICHAF					1.1	MAR	1/	Was	n
	Sta	te	31. Date filed (Month, Day, Year)	320R	Z/) legistrar's Signa	ture			/	7	11901	
	Registra	ar	MAY 0 3	2005	ever to	Apre	w					

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of I rtificate of			giene	5 14996
	Physic /Medi		Decedent's Name (First, Middle, Las     Michael Carl	Todd				2. Date of De Month April	ath	ear 2:41 P M
	Examir		4a. Facility Name (If not institution, give 1910 White House	street and number)		4b. City, Town, o	or Location of Dea		4c. County of	
	Funeral Director		219-60-9068	7. Ag M 2□ F	9e (In yrs. last birthday, 58 Yrs.	If Under 1 Year Months Days	if Under 24 Hr Hours Mir		h y, Year)	Birthplace (State or Foreign Country) (aryland
	e Maryland ie-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Harford		10c. City, Town or Le					10d. Inside City Limits 1 ☐ Yes 2 ➡No
	th with th	al Director	10e. Street and Number 1910 White Hous	se Road		10f. Zip Code	015		10g. Citizen of Wha	·
036	be filed within 72 hours after death with the Maryland stat Hygiene. od other than "naturel", or itams 23a or 28e-f show event, the Middeal Examinar must be rotified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Opproced	12. Was Decedent Armed Forces?  1 Yes 2 If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2√2 No	dispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- to Rican, etc.)	14. Race -	American Indian, White, etc. White
21215-0036	within 72 ho ene. than "natur he Mcdical.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ication le co <i>mpleted)</i> College (1-4or s	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo d)	orking	16b. Kind of Busin	
	buld be filed within Mental Hygiene. arked othar than ' etic evant, Ins Ma	o Be	17. Father's Name (First, Middle, Last)	ld, Jr.	CLOP	& Dairy			Farming Maiden Sumame)	
Maryland	s m	1	19a. Informant's Name/Relationship (T)	урв, Print) SC	711		and Number or R	ural Route Numbe	Roberts r, City or Town, Sta	
Baltimore, I	permit. Pages 1 and 2 Department of Health importent: if itam 27 i any injury or othar tra once.		Christopher Michae  20a. Method of Disposition  1  Burial 2 Cremation 3    4  Donation 5  Other (Specify)	Removal from State	cemetery, crei	White Hol sition (Name of matory or other plac Service (	ce)	Date	, Marylar 20c. Location - City Towson, I	y or Town, State
Balti	permit. Departming importe any injuite.		21. Signature of uneral Service Licens	mge /	M 1	Name and Addre CCOMAS FU 317 Cokes	ss of Facility ineral Ho sbury Roa	ome, P.A.	idon, Mar	yland 21009
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	a consequence of):	er the mode of dyin	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
8760,	icate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o	a consequence of): a consequence of):					
P.O. Box 68	death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy	,		23d. Date of Month	delivery Day Year
Ś	-≅ ω rs	by	Part II. Dther significant conditions co.	ntributing to death bi	ut not resulting in the ur	nderlying cause give	en in Part I.			e to the cause of death?
Vital Record		e Completed	25. Was case referred to medical						prior death	
o uc	ding Phys .r After this funeral di	To B	examiner?	lospital: 1	y 28b. Time of	28c. Injury Work	er: 4 ☐ Nursing H		e) ence 6 □Other (S ow injury occurred	Specify)
Divis	To the Hospitel or Attentwithin 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc.	iry - At home, farm, stre :. (Specify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or n. State)	Rural Route Number,
	To tha Hospital or within 24 hours after To tha Funaral Discompletely filled in	edical	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Examination	sician: To the best oner: On the basis of and manner sta	of my knowledge, death examination and/or inv ted.	occurred at the timestigation, in my op	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner ate and place, and o	as stated. due to the cause(s)
	To t To t	Σ	29b. Signature and the of certifier	MD		29c. License	8 487	29	9d. Date signed (Mo	onth, Day, Year)
	1,3		30. Name and address of person who co	mpleted cause of de		Print) WOOD	ROAG	) AFI	AIR S	21014
Ť.	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 3 20	32. egistra	r's Signature	ale		, 1,00	1,11-0	

Please	Type or	Print in	Black	Indelible	Ink.	<b>Ensure</b>	All	Copies	Are	Legib	le
	State	of Manda	nd / Da		-4 I L		1 8 4 -			60 m m	

HENRY TROCIUK State of Maryland / Department of Health and Mental Hygiepe 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Henry A. Trociuk, Jr. 0215 A M APRII 30, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE CITY n/a If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Director 215-80-3470 41 Maryland Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examiner is ust be notified at 1 Yes 2 No Directo Md n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or Itams 23a 3816 Hudson Street 21224 USA 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No <u>م</u> Specify Specify: 3 ☐ Widowed 4 ☑ Divorced White "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within and Mental Hygiene.

Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Carpet Installer 0 Carpet 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry A. Trociuk, Sr. Agnes Isaacs ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is rr any Injury or other traum once. Mrs. Agnes Trociuk/ Mother 3816 Hudson St. Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holy Rosary Ceme. 5/4/05 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funer Service Idenses Dundalk, Md. Kaczorowski Funeral Home P. A. Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Shew Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, leading to minimize cause. Enter Underlying Cause (Disease or injury Disa to (or as a nonsequence of) Examiner The law requires that the death certificate be executed the attending physician and ned for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 X No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No 24a. Was an has le 2 autopsy performed? certificate 2 □ No 1 X Yes To the Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No Certification: To 1 ☐ Inpatient XX ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Pay Year) 4/30/2005 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Subject stabled and 1 Natural 5 Pending death. 0:00 investigation М 1 ☐ Yes 2 No 2 Accident Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) by 4 Homicide Bay within 24 hours at To the Funaral D 3800 Hudson street, battimore 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

WMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E APRIL 30, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201 31. Date filed (Month, Day, Year) egistrar's Signature State MAY 0 3 2005

DHMH 17 Rev 1/200

Registrar

			For State Registrar		State of Ma	ıryland / I		artment of F rtificate of	lealth and N Death		iene () () = <sub>eg. No.</sub>	4998
	Physici	an	1. Decedent's Name (First, Mic Margaret N.	- 1	•					2. Date of Deat Month april 2	7, Day 2005	3. Time of Death 4:50 AM M
1	/Medic Examir		4a. Facility Name (If not institution Fairhaven Nu 5. Social Security Number	ion, give	street and number)	(In yrs. last bi	thday)		r Location of Death	8. Date of Birth	4c. County of D	eath
	Funeral Director		227-09-4141 Usuel Residence of Decedent		_ м 2Дг	90	Yrs.	Months Days	Hours Min.	Oct 29,	Year) 1914 \ \	Birthplece (State or Foreign Country) Tirginia
	nyland show		10a. State 10b. Cour	•		10c. City, Tow					-	10d. Inside City Limits
	the Ma 28a-f	ecto	MD Car	roll		Sy	kes	ville 10f. Zip Code		1	0g. Citizen of What	1 Yes 2 No
	3a or	i Dir	7200 Third Av	enue				Tot. Zip Code	21784	1	USA	Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Madical Examiter must be mailied at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ M  3 🏋 Widowed 4 □ Divorce		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cubin 1 ☐ Yes 2 ☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		merican Indian, Thite, etc. Vhite
200	72 hou natura lical E	eted	15. Deced (Specify only hig	ent's Edu	ucation	16a	. Deced	dent's Usual Occup	oation during most of work	ing	16b. Kind of Busine	ss/Industry
21215-0036	within ne.	Completed	Elementary/Secondary (0-12		College (1-4or 5	+) n	iife. i	DO NOT use retire	d)		laundwr/	l 1
q 7	filed v Hygie other 1 ent, Ib		17. Father's Name (First, Midd	le, Last)			iarra	601	18. Mother's Nam			lry cleaning
/lan	uld be Mental irked c	To Be	James W. No.	Land					Katheri	n Chilto	n	
Maryland	2 sho and ? !s ma		19a. Informant's Name/Relation			1		-	and Number or Run		·	e, Zip Code)
	1 and Health em 27	- 6	Penny Hopkins  20a. Method of Disposition	/ dau	ghter	20b. Place o	f Dispo	sition (Name of	le Court		s, MD 2.	1403 or Town, State
altimore,	t. Pages rtment of rtant: If it njury or c	1	1 ☐ Burial 2 ☐ Cremation 4 ※ Donation 5 ☐ Other	(Specify)		1		natory or other place				
Bal	permi Depa impo any ir		21. Signature of Funeral Scotl	ce Sicens	Wade, Dir	ctor	2.1	ate Afac iltimore,	មាក្ <sup>ac</sup> Bbard MD 2120		Baltimor	e Street
	Fnysician /Medical Examiner		23a. Part1. Enter the disease, shock, or heart failure. Limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	ist only o	a. Due to (or as a	e. Smì C I consequence	of):	er the mode of dyir		or respiratory arre		Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	edicai Examiner	Sequentially list conditions, any, leaving to investing cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	с	consequence						
P.O. Box (	the death certify the attending ched for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2	23c. If yes, outcome of 1 □ Live birth 1 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetel death		Ectopic pregnancy Other (specify)	<u> </u>		23d. Date of Month	delivery Day Year
	law requires that as been signed b 2 should be deta	þ	Part II. Other significant cond	itions co	ntributing to death bu	t not resulting i	n the ur	nderlying cause giv	en in Part I.		_	to the cause of death?  Probably 4 Unknown
Vital Records,	The ate h page	Completed								24a. Was ar autops perform 1 □ Yes 2	prior death	autopsy findings available o completion of cause of ? es 2 \( \text{No}\)
Ĭ.	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medi examiner? 1 ☐ Yes = 2 ☒ No	-	Hospital:	nt 2□ER/Oı	taation	t 3 DOA Oth	26. Place of Death	CAT LET BITTER TO THE	nce 6 Other (S	
1 0	g Phys er this ieral di	n: To	27. Manner of Death		28a. Date of Injur (Month, Day	28b.	Time of	28c. Injur Wor	The second secon	28d. Describe ho		pecity)
sion	Attending I ir death. ector: Alter by the luner	atio	E	stigation	(World), Day	7047)	injury		Yes 2 □ No			
Division of	tal or Attences after death birector; ed in by the	Certification;	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	imined	28e. Place of Inju building, etc		rm, str	eet, factory, office		28f. Location (Str City or Town		Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: Alter th completely filled in by the funeral	edicai	29a. Certifier 1 Certif (Check only one) 2 Medic	ying Phy al Exami	sician: To the best of ner: On the basis of and manner star	examination ar	d/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occurr	and due to the ca red at the time, da	use(s) and manner te and place, and c	as stated. lue to the cause(s)
)	To t within To tl	Σ	29b. Signature and title of cert	fier	MD			29c. Licens	e number 4849	A	od. Date signed (Mo	onth, Day, Year)
			30. Name and address of pers	10	n MD	ath (Item 23a)	- 4	Print) DENS Rd	Eldes	bus 1	10 2178	54
	Sta	-	31. Date filed Manty Day, 39	2005	32. Registra	r's Signature	/-	•				
DH	Registr				18-18-18-18-18-18-18-18-18-18-18-18-18-1	N. 19	ABA)	v				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland /		ealth and Me	ntal Hygien	e005	14999
>	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Las	Webb	4b. City, Town, or	1	Date of Death Month Da	ay Year	
	Funeral Director		5. Social Security Number 6. Sec. 213-32-62-28 1	Tognital 7. Age (In yrs. last L M 20 F 67	birthday) If Under 1 Year Months Days	fi Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Year, 918/37	3 9/ 2 in 9. Birth 7 M	a he splace (State or Foreign untry)
	ne Maryland Ba-f show diffied at	ctor	10a. State 10b. County	10c. City, To	own or Location ultimore				10d. Inside City Limits 1  Yes 2  No
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23e or 28e-f show event, the Medical Examinar must be notified at	Funeral Director	57-21 Pemor	oke Avenue  12. Was Decedent Ever in U.S. Amped Forces?	10f. Zip Code 212 13. Was Decedent of His	panic Origin? (Specif	v Yes or No-	itizen of What Con US 14. Race - Amer	rican Indian,
5-0036	2 hours after atural', or ite	by	1 Never Married 2 Married 3 Widowed 4 Divorced	lf Yes 2 ☐ No If Yes, Give Year or Dates:	1 Yes 2 No	n, Mexican, Puerto Ric		Specify: Slack, White	acK
2121	filed within 73 Hygiene. ither than "nother	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done de life. DO NOT use retired)	Directo	r Fee	deral (	Gov't
Maryland	should be fand Mental Bis marked of	To Be	Gilbert F. V	Vebb, Sr.	9b. Mailing Address A treet ar	18. Mother's Name (F	i Ross		in Code
	1 and 2 Health a Bm 27 is ther tree		Lois Webb/ 20a. Method of Disposition	Nite 5	721 Fem of Disposition (Name of	broke k	Baltimor	117	21207
Baltimore,	permit. Pages Department of Importent: If It any injury or o		1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify, 1 Ignature) of Funeral Service Licens	Garr	22. Name and Address	of Facility Vaug	h.C. Gra	ings/	1:16 MD al Services
	*		23a. Party Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	lications that caused the death. Do	o not enter the mode of dying,	, such as cardiac or re		un, MD	Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death)	a Due x (or as a consequence	e of):				
/\'no/8	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence  Due to (or as a consequence					
O. Box 68	death certifi e attending id for use as	hysician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	th 3 Ectopic pregnancy 5 Other (specify)			23d. Date of delive	ery Day Year
ras, r.	tuires that n signed by ald be deta	by P	Part II. Other significant conditions co.		in the underlying cause given	in Part I.	23e. Did tobacco u	<u>.</u>	he cause of death?
al Record	: The law requires that the cate has been signed by th r page 2 should be detache	Completed	V /				24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No	prior to co death?	opsy findings available mpletion of cause of
ion of vital	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: Attenthis certificate has completely filled in by the funeral director, page 2 or preserved.	atlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		Other: Time of Injury  28c. Injury a Work?	4 U Nursing Home			y)
DIVISION	pitel or Atte	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)		1	Location (Street and City or Town, State)	)	
	the Hos thin 24 ho the Fun mpletely f	Medical	29a. Certifier (Check only one)  29b. Signature and title of certifier	sician: To the best of my knowledg ner: On the basis of examination ar and manner stated.	nd/or investigation, in my opin	nion, death occurred a	t the time, date and	place, and due to	the cause(s)
)	To With	_	Alice H	5.	29c. License r	29-11		e signed (Month,	, ,
	10		30. Name and address of person who co	mpleted cause of death (Item 23a)	(Type, Print)	Raadai		i i.	lovel
	Sta Registra		31. Date filed (MAY) 3. 3 2005	32. Registrar's Signature	perker 1 1 2 1	/CAAdal	1 stenn	Mary	1140

			1 - For State Registrar	State of N	Maryland / Depa Ce	artment of Hertificate of D			giene ()	05	15000		
	Dhusis		Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath		3. Time of Death		
	Physici /Medi		LOUISE	ROSE	WOERNER			MAY	2, Day 2	005 <sup>Year</sup>	8:45 A. M		
	Examir	ner	4a. Facility Name (If not institution	n, give street and numbe	e street and number)		4b. City, Town, or Location of Death		4c. Cou	c. County of Death			
			CONTINUING CARE SYKESVILLE  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)			SYKESVILLE If Under 1 Year If Under 24 Hrs. 8. Date of 8i			CARROLL				
	Funeral Director		5. Social Security Number 214-01-2174  Usual Residence of Decedent	Age (In yrs. last birthday)  86  Yrs.	Months Days Hours Min			n, Year) <b>191</b> 8	Cou	9. Birthplace (State or Foreign Country) MARYLAND			
	vland ow		10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits		
	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Jenn 271s marked other then "natural", or Iteme 23s or 28s-f show other traumatic event, it a Marical Examination using the notified at	Funeral Director	MD CARE	OTTSVILLE					1 ☐ Yes 2 X No				
			10e. Street and Number 10f. Zip Code				10g.			of What Cou	intry?		
		aiD	2406 FOREST HI	21104	21104								
imore, Maryland 2		by	11. Marital Status  1 □ Never Married 2 □ Mar  3 ※ Widowed 4 □ Divorced	If Vac Give	? ] No	Was Decedent of His If Yes, specify Cuban I□ Yes 2□Wo	panic Origin? (Spe , Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	E	Race - Ameri Black, White cify: WH			
		Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed) College (1-4or	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)		ng	16b. Kind of	Business/Ir			
	lled w Hygier her ti		12TH GRADE	( ant)	HOME	MAKER			OWN				
	ntai H ed oti	Be	17. Father's Name (First, Middle,	•		1	8. Mother's Name		Maiden Surr	ame)			
	should ba filed within and Mental Hygiene. s marked other then " tumatic event, It a Mex	2	JOSEPH GIUNTA  19a. Informant's Name/Relations		10h Mailir	ng Address (Street an	MARY LIE			21.1.7			
	and 2 sho salth and In 27 Is ma		MARY ANN BECHT			FOREST H							
	Fages 1 and 3 nent of Health int: if item 27 iry or other tra		20a. Method of Disposition  1  Burial 2  Cremation	3 □Removal from State	20b. Place of Dispo	sition (Name of	D		20c. Locatio	n - City or T	own, State		
			*4 □ Donation 5 □ Other (S 21. Sign turn of Funeral Service		GARD	ENS . Name and Address	2/0/2	-	COCKE		•		
Ba	Departr Departr Imports any inju	1 /	Heathe	N. Hark	- 8	3521 LOCH	RAVEN BL	VD. TO	WSON,		HOME, P.A. 1286		
	Physician /Medical		23a Part 1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	line.				est,		Approximate Interval Between		
										Onset and Death			
	Examiner		Total and a second	Due to (or as	s a consequence of): 1								
		ē	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	b Due to (or as a consequence of):								
	uted ansit	Examiner	Sequentially list conditions, if any, leading to immediate dates. Enter Underlying Cause (Disease or injury that initiated events										
	cate be exacuted physician and the burial-transit	Exa	resulting in death) Last	Due to (or as	Due to (or as a consequence of):								
		dicai		d									
	rtifica ng ph as th	Medi	IE EENALE										
	by the attending placehed for use as	y Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1						23d. Date of delivery  Month Day Year				
	that		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?				
	n. After this certifica funeral director, p	ted by						1 ☐ Yes 2 ♠ No 3 ☐ Probably 4 ☐ Unknown					
		ertification; To Be Completed						24a. Was a autops perform 1 Yes 2	<u>ا م</u> ۷	D. Were auto prior to condeath? 1 \( \text{Yes} \)	psy findings available mpletion of cause of 2 No		
			25. Was case referred to medical examiner? 1 \sum Yes2 \sum No	Hospital:		Other	6. Place of Death						
			27. Man r of Death  1 Natural 5 Pendin 2 Accident investig		ury 28b. Time of	28c. Injury a Work?	4 Nursing Hom t 29 s 2 □ No	e 5 🗌 Reside 8d. Describe ho			у)		
	al or Attences after death	Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						ff. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or, within 24 hours after To the Funeral Director Completely filled in the	edical (	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	To the within 2 To the complet	29b. Signature and title of certifier					umber	29d. Date signed (Month, Day, Year)					
	/		<b>)</b>	Join y	MY	1000	59943		MBY 3	1, 20	02		
(0	0		30. Name and address of person	who completed cause of o	death (Item 23a) (Type, F	Print)	307	wastr		MI	2/157		
Ĭ	Sta Registra		31. Date filed (Month, Day, Year)	2005 32. F gistr	rar's Signature	wit	1	1	7)	å . j laner			